STATE OF MICHIGAN
IN THE SUPREME COURT
APPEAL FROM THE MICHIGAN COURT OF APPEALS

ROBERTO LANDIN,

Plaintiff-Appellee,

Supreme Court No.: 149663
Lower Court File No. 08-002400-NZ-3
Court of Appeals No.: 309258

vs.

HEALTHSOURCE SAGINAW, INC.

Defendant-Appellant.
_____/

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PLAINTIFF-APPELLEE'S BRIEF ON APPEAL

ORAL ARGUMENT REQUESTED

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WHETHER MICHIGAN PUBLIC POLICY, AS DEMONSTRATED BY EXPLICIT LEGISLATIVE STATEMENTS IN THE PUBLIC HEALTH CODE, THE MICHIGAN CONSTITUTION, THE REGULATORY FRAMEWORK OF THE MICHIGAN ADMINISTRATIVE CODE THAT INCORPORATES A NURSE'S CODE OF PROFESSIONAL RESPONSIBILITY INTO A REGULATORY SCHEME, AS WELL AS THE COMMON LAW, PROHIBITS A HOSPITAL FROM DISCHARGING A NURSE IN RETALIATION FOR THE NURSE REPORTING TO HIS/HER SUPERVISOR THAT ANOTHER NURSE NEGLIGENTLY KILLED OR PRECIPITATED THE DEATH OF A PATIENT, AND THAT THE REPORTING NURSE FEARED THAT THE INCOMPETENT NURSE POSED A CLEAR DANGER TO OTHER PATIENTS IN THE HOSPITAL?

Court of Appeals Answered "YES"
Trial Court Answered "YES"
Plaintiff-Appellee Answers "YES"
Defendant-Appellant Answers "NO"

II.

WHETHER THE WHISTLEBLOWER PROTECTION ACT (WPA) IS THE APPELLEE, ROBERTO LANDIN'S, EXCLUSIVE REMEDY IN A CLAIM FOR WRONGFUL DISCHARGE IN VIOLATION OF PUBLIC POLICY, WHERE THE WHISTLEBLOWER PROTECTION ACT PROVIDED NO REMEDY BECAUSE THE APPELLEE, LANDIN, IS NOT A "WHISTLEBLOWER" AS THAT TERM IS DEFINED PURSUANT TO THE WPA?

Court of Appeals Answered "NO"
Trial Court Answered "NO"
Plaintiff-Appellee Answers "NO"
Defendant-Appellant Answers "YES"

COUNTER STATEMENT OF ORDER APPEALED FROM AND RELIEF SOUGHT

The Court of Appeals, contrary to the representations of the Appellant, Healthsource, correctly explained that the Trial Court, in denying the Appellant's Motion for Summary Disposition, held that "Michigan law recognized a cause of wrongful termination in violation of the public policy exhibited by MCL 333.20176(a)". *Landin v. Healthsource,* 305 Mich App 519, 532; 854 NW2d 152, 163. The unanimous panel further declared that the public policy legislatively set forth in MCL 333.20176(a), fulfilled two prongs of the public policy doctrine enunciated in this Court's Opinion in *Suchodolski v. Michigan Consolidated Gas*, 412 Mich 692; 292 NW2d 880 (1982)]. The Court stated that in enacting the Public Health Code, the purpose of the legislature was, in part, to "safeguard the public health and protect the public from incompetence, deception and fraud." *Landin, supra, citing Michigan Ass', of Psychotherapy Clinics v. Blue Cross Blue Shield of Michigan*, 118 Mich App. 505, 522; 325 NW2d 471 (1982). The declaration found in The Public Health Code, is likewise mirrored by legislative statements found in the Michigan Constitution, and The Michigan Administrative Code. The latter, by regulating the nursing profession, incorporates the professional responsibilities of nurses into a regulatory framework. [*See infra*].

The Court in *Landin* also recognized that allowing the retaliatory discharge for reporting malpractice would discourage, "the fulfillment of this legislative policy by use of the most powerful weapon at the disposal to the employer, termination of employment, is obviously against the public policy of our state". *Landin supra*, @ 531 *citing Sventko v. Kroger Co.*, 69 Mich App 644, 648; 245 NW2d 151 (1976).

The Court of Appeals correctly explained that two of the applicable public policy exceptions of the at-will employment doctrine, articulated in *Suchodolski*, *supra* apply to this case as described by the trial court. Those exceptions are that (1) it contains an explicit legislative prohibiting discharge...or other adverse treatment of employees who act in accordance with a statutory right or duty and (3) where the reason for the discharge was the employees exercise of a right conferred by a well-established legislative enactment. The Court of Appeals explained that both prongs 1 and 3 of *Suchodolski* were present in this case. Specifically, "MCL 333.20176(a) contains an explicit legislative statement prohibiting discharge or discipline of an employee for specified conduct. It could also be argued that the specified conduct was of acting in accordance with a statutory right or duty." *Landin, supra* @529. In relation to the third exception articulated in *Suchodolski* the Court of Appeals declared,

> "In enacting MCL 333.20176(a), the Legislature clearly expressed a desire to further that policy by prohibiting retaliation against an employee who reports malpractice. And, the right to report alleged acts of negligence (malpractice) is consistent with and implicit in the purposes of the Public Health Code and its statutory regulations governing health care professionals.
>
> For the same reason, exception (3) in Suchodolski, (citations omitted) (where the reason for the discharge was the employee's exercise of a right conferred by well-established legislative enactment) could also apply to MCL 333.20176(a)." *Landin* @ 530.

The decision of the Court of Appeals, affirming the trial court, is also consistent with other indicia of legislative intent of public policy as declared by this Court in *Terrien v. Zwit*, 467 Mich 56; 648 NW2d 602 (2002) wherein this Court acknowledged that a public policy claim must be rooted in something more than the personal preferences of individual judges. As such, the Court explained:

> **"We note that, besides constitutions, statutes, and the common law, administrative rules and regulations, and public rules of professional conduct may also constitute definitive indicators of public policy".** *See Terrien supra*, FN 11, p. 67, (Emphasis Added).

In this case the Michigan Constitution, the Public Health Code, Mr. Landin's professional responsibilities as a nurse, as embodied within the licensing provisions of the Michigan Administrative Code, as well as well-established common law all dictate that it is against the public policy of Michigan to allow an employer to discharge an employee in retaliation of reporting the malpractice of a co-worker, resulting and/or precipitating the death of a patient. Not only is the act of retaliation against the public policy of the state, but the failure to protect a nurse for fulfilling his/her professional obligations, as illustrated by the nurse's code of professional responsibility as adopted by the Michigan licensing rules via the Michigan Administrative Code, would have a chilling effect on other employees from fulfilling their professional responsibilities and, overall, have a deleterious affect on the public health and safety in Michigan. Likewise, it would have the effect of shielding the inept, and silencing the competent.

Healthsource's request to have this Court determine that the Michigan Whistleblower Protection Act (WPA), MCL 15.361, *et seq*, provides the exclusive remedy in this case is equally arcane. Because Landin made only an internal report, following the chain of command as he was instructed to do, he never reported or threatened to report wrongdoing to a "public body" as that term is defined within the WPA. Therefore, he had no remedy under the WPA. An exclusive remedy does not apply where the remedy "does not exist, is plainly inadequate, and/or deficient". *Mack v. City of Detroit*, 254 Mich App 498; 658 NW2d 492 (2002). *[See infra].*

Appellee, Landin, respectfully requests that this Court protect the public health of the State of Michigan, in accordance with legislative statements found in the Michigan Constitution, the Public Health Code, and the Michigan Administrative Code that embraces the duties and professional obligations of nurses, and affirm the decision of the Michigan Court of Appeals.

I. OVERVIEW

Appellant Healthsource, under the guise of protecting at-will employment and insulating the state from a floodgate of illusory litigation, urges this Court to sacrifice the safety of Michigan's citizens, and overturn the jury's correct conclusion, as unanimously affirmed by the Michigan Court of Appeals, that Plaintiff-Appellee, Roberto Landin [hereinafter Landin], was the victim of a retaliatory termination in violation of Michigan's public policy for reporting the gross, incomprehensible, and deadly malpractice of another Healthsource nurse, Gayle Johnson.[1] The Appellant's position, if adopted, will protect the inept, silence the competent, and, in the process, undermine the public policy of this state to protect the public from incompetence, deception and fraud. *See Landin v. Healthsource*, 305 Mich App 519, 530; 854 NW2d 519 (2014) *citations omitted*. Furthermore, the interpretation is not consistent with the edict of the Legislature in demanding that the Public Health Code (PHC) "be liberally construed for the protection of the health, safety and welfare of the people of this state". MCL 333.1111.

Landin submits that the policy of trading patient safety, sacrificing human life and limb, is not a tradeoff that the Legislature envisioned when adopting the Michigan Constitution, passing the PHC, and incorporating the regulatory framework of the Michigan Administrative Code (Adm. Code). The Adm. Code incorporates a nurse's professional responsibility into a regulatory scheme that ensures that nurses are "patient advocates" and protect, preserve, and improve the health of Michigan's citizens. *See, Bureau of Professional Licensing, www.mi.gov.*

The second spurious claim made by the Appellant is the intimation that the trial judge, or the Court of Appeals, created public policy in the "absence of a legislative act or statute". [*See*, Healthsource Br. p. 1]. This misstatement is compounded by Appellant's repeated

[1] Ms. Johnson got married and her married name is Conic. As she was referred to as Johnson throughout all depositions and discovery she will be referred to as Johnson throughout.

mischaracterizations of this Court's holding in *Terrien v. Zwit*, 467 Mich 56; 648 NW2d 602 (2002). Healthsource wrongfully asserts that the court of appeals decision herein "guts" this Court's holding in *Terrien v. Zwit*. 467 Mich 56; 648 NW2d 602 (2002). [Healthsource br. p. 1]. Equally erroneous is the claim that the Court's decision in *Terrien* is a departure from, *Suchodolski v. Michigan Consol Gas Co*, 412 Mich 692; 292 NW2d 880 (1982). *Terrien* merely provides a more detailed roadmap in explaining how one determines public policy. The Court explained:

> "We note that, besides constitutions, statutes, and the common law, administrative rules and regulations, and the public rules of professional conduct may also constitute definitive indicators of public policy". *Terrien, supra*, FN 11, p. 67.

In this case, fertile fields of public policy are found in all of the aforementioned arenas. The Michigan Constitution states that public health and welfare are matters of primary concern. The Court of Appeals, as did the trial court, pointed to the PHC, MCL 333.20176a, that provides:

> "Sec. 20176a. (1) **A health facility or agency shall not discharge or discipline, threaten to discharge or discipline, or otherwise discriminate against an employee regarding the employee's compensation, terms, conditions, location, or privileges of employment because the employee or an individual acting on behalf of the employee does either or both of the following:**
> (a) **In good faith reports or intends to report, verbally or in writing, the malpractice of a health professional or a violation of this article,** article 7, or article 15 or a rule promulgated under this article, article 7, or article 15.... [Emphasis Added].

Landin testified his role as a nurse is to be a "patient advocate". [Appx. 1 p. **5b**] [2]. That comports with professional obligations of a nurse, as subsumed within the regulatory framework of the Michigan Administrative Code. Appellant further erred in arguing that *Terrien* excluded codes of professional responsibility, as sources of public policy. [Appellant br. p. 31, fn 19].

[2] Consistent with MCR 7.308, Appellee has not duplicated any exhibits, except where clarification is needed. Appellee has bolded the letters to clarify which Appendix is involved.

Landin is an LPN with over twenty-five (25) years of experience, trained in the navy for combat medicine and was decorated while doing so, and is a person who obtained good to excellent evaluations at Healthsource for every year his records were produced by Healthsource.

On February 25, 2006 Landin came into work to find out that the man that he had treated for almost two years, Jack, was dead. After some extensive investigation, Landin concluded that the nurse on call, Gayle Johnson, had negligently caused or precipitated the death of Jack. Landin wrote an internal memo to the Nurse Manager, Amber Boyk, that he believed that Johnson caused the death and was dangerous. The Variance and Concern Report (V&CR) authored by Landin stated, in part, as follows:

> "Amber I am concerned that a resident (Jack__) **has died [due] to the neglect of a nurse (Gayle)...**The resident was...exhibiting the signs and symptoms of Hypoglycemia @ 1:30 in the morning. Why was not the Blood Sugar checked? Again the above noted nurse documented **"will continue to monitor", so why didn't she look in on the resident sooner than four hours and fifteen minutes later**? I believe that Jack -------- received a larger dose of insulin than he needed, [he was very unstable] **he was not properly or safely followed up [his sugar was level not monitored post injection]**. That I believe that **his death could have been avoided** and that his fall out of bed at 01:30 was symptomatic to his physical reaction to the drop of his blood sugar...**I believe that the above nurse is dangerous**" [Appx. 39, p. 180**a**].[Emphasis Added].

Less than one month prior to killing or precipitating the death of Jack, Ms. Johnson was removed from the skilled nursing floor for failing to do 12 of 16 dressing changes, because she was "too busy". She also failed to get coverage for the procedures. The result, as noted in the discipline, could be the patient going septic, losing a foot to amputation, and/or death from septacemia. [Appx. 36 p. 167**b**]. The discipline was equally prophetic, it warned:

> "[Johnson] will be transferring to [long term care], by 06 February and oversight is not as frequent, but the need to maintain appropriate response to patient needs is just a prescient and prioritizing is just as critical". [Appx 36, p. 167**b**].[3]

[3] The skill cared floor's gain (Johnson's removal) was the death-knell of Jack. He died within weeks of having Johnson as his provider because Johnson "could not prioritize". Had she just checked his blood sugars, Jack, in all likelihood, would not have died on that night.

The pervasive incompetence of Ms. Johnson was evident throughout the trial. Judge Boes observed, "...I did not think that Gayle Johnson came across as competent. In fact, she seemed to have a startling, if not appalling, lack of knowledge. [App. 56 p. 212**b**]. Johnson committed more serious errors in one night, than many nurses commit in a lifetime. *See infra*.

Within one week of reporting that Johnson was "dangerous", and that she precipitated the death of "Jack", Ms. Johnson, and the supervisor, Amber Boyk, documented two technical infractions by Landin. Appellant erroneously refers to these "technical" infractions as "falsifying" a medical record.[4] About six (6) weeks later Johnson fabricated a third event that Landin had not given medications to a head injured/epileptic patient, Scott B. The record demonstrated, however, that Landin gave Scott his medications. [Appx. 10, p. 128**b**]. Ms. Johnson erred again and wrote the wrong date on the alleged infraction, 4/23/04 as opposed to 4/23/06. [Appx. 50 p. 195**b**].[5] The evidence demonstrated that Boyk then subsequently forged documents, including a document allegedly written by a deceased nurse, Dale Pettelle, to further discredit Landin.[6] The overwhelming evidence also demonstrated that Boyk destroyed all of the evaluations that she performed on Landin and Johnson. *See infra*.

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[4] Healthsource Policy #115, defines, in very ambiguous terms, a series of actions that constitute Group I or Group II violations. Despite repeatedly referring to the Plaintiff's actions as "falsifying" documents, the evidence did not support that claim. *See*, Appx. 22, p. 146**a.**

[5] Unredacted document submitted to court of appeals under seal. Compare to redacted document Appx. 31 p. 160**a**.

[6] Appellant's Appx 31, 160**a**/Appx. 50 p. 19**5b,** is the document that is misdated. Johnson put 4/23/04 as the date. In parenthesis, however, it is correctly marked (06). After years passed, and discovery progressed, Boyk then created a document under the name of Dale Pettelle, a nurse who had passed away between the time of Landin's termination and trial. Pettelle, in the past, had been very critical of Johnson. *See* Appx. 36, p. 167**b**. In addition, Boyk created an alleged diary notation of her own, to discredit Landin. The note that is penned by Boyk under the name Dale Pettelle is in the Appellee's Appx. 29 p. 155**b**. It states, allegedly on the day after Landin reported Johnson killed Jack, that Landin is retaliating for being "**written up**" by Johnson for not passing medications to [Scott]. There was, however no "write-up" prior to

The Whistleblower Protection Act (WPA), MCL 15.361 *et seq.*, is not the exclusive remedy for Landin. It is generally true that where a new right or duty is created by statute, that remedy is exclusive. That not apply, however, where the remedy does not exist, is plainly inadequate, or deficient. *Mack v. City of Detroit*, 254 Mich App 498; 658 NW2d 492 (2002).

II. COUNTER-STATEMENT OF FACTS

Roberto Landin is a married father of three children. He is a 1983 graduate of Saginaw Practical Nursing School [Appx. 11 p. 129**b**]. Landin worked as a licensed practical nurse (LPN) for twenty-five (25) years. [Appx. 1, pp. 7**b**-8**b**]. He was never fired prior to this case.[7]

His first job was at Midland Hospital (MH). In 1985 Landin left MH and joined the navy. In the navy he received extensive training and was decorated. [Appx. 1, pp. 7**b**-8**b**].[8] Later, Landin worked at many hospitals, always voluntarily leaving for better pay and/or conditions. In 2001, while at St. Luke's Hospital (1996-2003), Landin started working at Healthsource and became fulltime in 2004. [Appx. 1, p. 4**b**]. Healthsource included a long-term care facility. Mr. Landin viewed his role, as an LPN, to be a **patient advocate**. [Appx. 1 p. 5**b**].

4/23/06. Therefore the "write-up" had not yet occurred. One knows that Boyk did it by referring to her own diary notes wherein she also created a document that she "Spoke to Dale" …found pills in med cart (Scott). This diary allegedly started on 2/27/06 and ends on 2/28/06. Yet in the middle, it references an event with Scott that did not occur until April 23, 2006. [Appellee's Appx. 52 p. 197**b**]. Appx. 51, p. 196**b** and Appx. 52, p. 197**b**, are the actual sealed documents and use Scott's last name]. One can compare the redacted versions with the actual versions. [See, Appx 29, p. 155**b** and compare to actual Appx 51, p. 196**b**]. Not only did Boyk create these documents, there is also ample evidence that she destroyed the personnel records for Landin and Johnson for the years that she supervised both of them. That is, the records for all reviews for Landin and Johnson, that were performed by Boyk, all mysteriously disappeared. [*See Infra*].

[7] A reference timeline is attached as Appx. 53, @ 198-201**b**.

[8] Landin first became a corpsman. As he finished in the top 10% of his class, he was sent to Field Medical School. He trained to treat catastrophic military injuries. [Appx. 1, p. 3**b**; Appx. 14 p. 132**b**]. Landin won many awards. He earned an award for "Super Squad Recognition" [Id]. *See* Appx. 12, p. 130. He received awards for combat medical service. [Appx. 1 p. 3**b**; *See* Appx. 13, p. 131b and Appx. 14 132**b**]; Landin was stationed in live battle zones, and lost the vision in his right eye while in the service. [Appx. 1, p. 3**b**]. Landin was honorably discharged with "a greater love of home, a greater sense of honor [and] courage". [Appx. 1 p. 4**b**].

As an LPN Landin was to report to the Nurse Manager. [See, Job Description, Appx. 20 pp. 139**a**-140**a**]. Likewise, he was to be reviewed every year by his Nurse Manager. [Appx 1 p. 5**b**)]. Mr. Landin's reviews from 2001-2003, performed by someone other than Boyk, demonstrated Landin was a good to excellent nurse. [Appx. 43-49, pp. 174**b**-194**b**][9].

In 2004 Nurse Manager Amber Boyk became Landin's supervisor. She gave him good reviews as well. [Appx. 1, p. 5**b**]. However, when Landin obtained his file, the reviews were gone. [Appx. 1, p. 5**b**]. Comparable co-worker, Gayle Johnson's reviews, also performed by Boyk, were missing as well. [Appx. 19 pp. 140**b**-141**b**].[10]

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[9] In early reviews Landin was repeatedly described as being neat, punctual, hardworking and an **advocate for patients**. [Appx. 43, p. 174-175**b**]. He graded at "100%" in general work expectations and for job specific competency. [Appx. 44, pp. 176-179**b**; Appx. 49, p. 190**b**]. Landin was deemed qualified to train nurses in no less than (14) fourteen categories and was at least competent and/or able to act independently in **all other venues of nursing**. [Appx. 45, pp. 180-181**b** (rating of 4 allows nurse to train)]. Landin got along well and was excellent in patient confidentiality. Landin regularly graded out at the top of the scales and was thought to be "team player and a good advocate for residents and family". [Appx. 45-49, pp. 180-194**b**]. In one of the last reviews produced, it is noted that "Roberto is a very hard worker. He cares about the quality of care with his patients and gets along well with most of his peers. His medical background is an asset to our program…" Appx. 49, pp. 192-194**b**. [Emphasis added].

[10] Healthsource Policy 109 requires that supervisors "will provide an annual review of each employee's job performance based upon a position description" [Appx. 19, pp. 140**b**-141**b**]. Boyk testified that as Nurse Manager she performed all aspects of her job to the best of her abilities. Part of her job was to do annual evaluations of Landin. [Appx. 3, pp. 33**b**-34**b**]. Boyk admitted that she had access to the employee personnel files. [Id]. Sue Graham, the Nurse Executive at Healthsource, testified that Boyk, was supposed to perform evaluations yearly and that Boyk had unfettered access to place, and/or remove, documents from personnel files. [Appx. 7, p. 119**b**] The H.R. Director, Katie Adams, confirmed that Amber Boyk would have had access to the personnel files and could have added or removed documents at will. Adams could not explain the disappearance of Landin's or Johnson's most recent evaluations by Boyk. [Appx. 6, pp. 110**b**-111**b**]. Landin's evaluations from 2000-03 were in his file. [See Appx. 43-49, pp. 174**b**-194**b**]. Johnson testified at her deposition, that she did have an evaluation by Boyk and could not explain why it was not in her file. [Appx. 5, p. 75**b**]. Based on all of the other evidence, there is strong reason to believe that Boyk destroyed the relevant evaluations of Landin and Johnson, just as there is undisputable evidence that Boyk created a document under the name of a deceased nurse, Pettelle, in an effort to discredit Landin, and a corresponding document in her diary, to shield her own incompetence in hiring and failing to supervise Johnson *[See infra*].

Landin worked for almost four-years in the psych unit at Healthsource, before moving to long-term care. [Appx. 1, p. 6**b**]. On the psych unit medications were passed differently than on other floors. For most floors, the nurse takes the medication cart to the patient's room, confirms the patient, takes the meds to the patient, watches the patient take the medication, and then comes back and signs that the medication was given. [Appx. 1, p. 16**b**].[11] However, on the psych floor a nurse is not allowed to take the cart into the ward. If one took the cart into the psych ward the nurse would "be wearing the cart on your head". The residents are combative and can strike the nurses with the cart. [Appx. 1, p. 18**b**]. Landin explained that in his almost four years in the psych ward, the accepted procedure was one would gather the medications, sign them out, take them into the psych ward, watch the person take the meds and then return to the cart for the next patient. [Id]. In years of administering the medications in that manner Landin was never written up for, or accused of "falsifying" a document. Mr. Landin explained:

> "It just holds true. It's a good policy. Often you get sidetracked. Once you get in the back you never know what's going to happen, but stool and feces, people get combative so its easy where you could be sidetracked for a lengthy time, 15, 20 minutes and hour. But what happens is if I don't sign it, someone else looks at it. If he looks at the mark and says this wasn't given, and someone could get double-dosed". [Appx. 1, p. 18**b**].

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[11] Landin explained that some medications come in blister packs and others come in bulk bottles. Some medications were brought by family members in bulk bottles to save money. [Appx. 1, p. 16**b**]. Each resident has its own drawer in the medication cart. The nurse has access to all of the drawers. Scott B. was a patient who was at the facility for only about 6-7 months. Scott had a history of seizures and had a closed head injury when he was a younger man. According to Mr. Landin, Scott had a closed head injury and appeared mentally retarded as a result of the head injury. In addition, Scott had short-term memory loss and was in his forties at the time of trial. Scott's mother brought certain medications in bulk that got to the medication cart through her delivery of the drugs to the pharmacy. [Appx. 1, pp. 16**b**-17**b**]. Scott's medication administration record, that was supplied by the Defendant in response to Production of Document Requests, was admitted as Appx. 17, p. 136**b**. This document covers the month of April 2006. If one looks down the column for April 23, 2006, the date that the Plaintiff allegedly did not give medications, one can see that Mr. Landin gave Scott his medications as he testified. Landin's initials are seen at 0900 and 1800 hours. [Appx. 1, p. 17**b**; Appx. 17, p. 136**b**].

In February 2006, Landin had been treating a patient, Jack, for about 18 months. [Appx. 1, p. 6**b**]. Landin was aware that Jack was a brittle diabetic. Brittle meaning that his blood sugars were subject to wide swings [Id]. Jack had other problems, and could not walk [Appx. 1, p. 7**b**].

A. LANDIN REPORTED TO HIS SUPERVISOR, AMBER BOYK, THAT LPN JOHNSON'S NEGLIGENCE CAUSED OR PRECIPITATED THE DEATH OF A HEALTHSOURCE PATIENT.

On February 25, 2006, Landin arrived at work before 7:00 a.m. The LPN working nights, Gayle Johnson, told Landin that Jack had fallen during the night and hit his head and passed away.[12] Landin had worked with Ms. Johnson as a nurse, and when Johnson was a CENA and unit secretary. Landin knew Johnson was transferred to his unit, 5a, because she was banished from the skilled floor. [Appx. 1, p. 8**b**].[13] He believed Johnson was not a good nurse, was not competent, thorough, or reliable. [Appx. 1, pp. 7**b**-8**b**].

After learning of Jack's death, Landin questioned Johnson regarding Jack's treatment. Johnson's demeanor changed, she became hostile, and told Landin "not to start any shit". **A**ppx.

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[12] Gayle Johnson was a comparable worker to the Plaintiff. They both were LPNs and they both reported to Boyk. [Appx. 1, p. 7**b**]. They worked the same floor but different shifts.

[13] Appx. 36, p. 167b is the "Coaching" Ms. Johnson received. It appears Ms. Johnson was transferred from the skilled floor, after numerous other nurses complained she was not doing dressing changes. Many people testified, the failure to perform dressing changes on severely ill diabetic patients could have severe ramifications including amputation and/or death. Despite failing to perform 12 out of 16 changes, each one independently a Group 1 violation [Appx. 22, pp. 146**a**-148**a**], and subject to termination, Ms. Johnson merely got a coaching. Johnson had already been suspended for a different group 1 violation for three days in November 2005. [Appx. 35, p. 166**b**]. On March 10, 2006, just a couple of weeks after Johnson was alleged to have killed Jack she failed to give a patient his medicine. Exactly what she erroneously claimed Landin had done. The fact was Landin gave Scott his medicine, *see infra*. Nevertheless, after getting suspended in November 2005, after failing to do 12/16 dressing changes, [each a group 1 violation] after failing to properly follow up on Jack causing or precipitating his death, and after failing to give medicines a few weeks later, on March 10, 2006, Johnson is coached for failing to give medications and not telling the truth about it [Appx. 37, p. 168**b** (emphasis added)].

3, p. 56**b**].[14]

Landin later reviewed the Medication Administrative Record (MAR). [Appx. 24, p. 150**b**]. The MAR shows there was a sliding scale to determine the amount of insulin Jack was to receive based on his blood sugars [Appx. 1, pp. 9**b**-10**b**]. The MAR demonstrated that on February 24, 2006 at 9:00 p.m., Jack was given 15 units of insulin for a blood sugar of 515. [Appx. 1, p. 10**b**].[15] That was more than double the dose of insulin Jack had been given at 9:00 p.m. any night in February 2006.[16] Landin explained the procedures that should have been done after a 515 reading. He would have repeated the test to rule out a false positive. Critically, after administering that amount of insulin, he would have checked on Jack hourly. [Appx. 1, p. 10**b**].

Landin also recounted that the nursing notes compiled by Johnson for Jack on the morning of his death, [Appx. 25, p. 151**b**], were devoid of any actions by Ms. Johnson. The nursing notes should reflect all actions of the nurse. Written orders are to be provided whenever available. Verbal orders are to be avoided and documented if necessary. [Appx. 1, p. 10**b**].

The nursing notes did not say when or if anyone was called when Jack's blood sugars were 515. Johnson did call a physician assistant, PA Lindsay, but the nursing notes failed to document what Johnson told PA Lindsay, or what he told her.[17] The log was devoid of any check by Johnson on Jack from 9:00 pm on the 24th until Jack was found by a CENA on his

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[14] Mr. Landin testified that Johnson did not take criticism well and reacted with anger. [Appx. 1, p. 8**b**]. Landin heard Johnson swear at him and others. When he complained to Boyk she got out of the area to avoid a confrontation with Ms. Johnson. [Appx. 1, pp. 8**b**-9**b**].

[15] Jack's blood sugar was 515 @2100 hours on 2/24/06. Find the notation for 2100 and follow to the column that corresponds with the twenty-fourth day of February. [Appx. 26, p. 152**b**].

[16] Appx. 24, p. 150**b**, Insulin, 2100 hours, next highest dosage of insulin for the month is 7 units.

[17] These are all violations of Healthsource policies. [*See* Appx. 18, pp. 137**b**-139**b**]. That policy regarding "Physician Orders" mandates that "verbal orders are to be taken by a nurse only in an emergency situation and require a verification read back of the complete order by the nurse receiving the order". It also violates another policy, "Communication-Physician Orders and Critical Test Results" [Appx. 20, pp. 142**b**-143**b**].

hands and knees in a pool of vomit and diarrhea at 1:30 am on the morning of the 25th. [Appx. 25, p. 151**b**; Appx. 1, pp. 11**b**-12**b**]. Johnson initialed it as 1:40 am in the nursing note.[18] Johnson also failed to check Jack's head and/or his neurological signs for a closed head injury since he had to have fallen out of bed [Appx. 1, p. 12**b**].[19] Incredibly, Johnson did not check Jack's blood sugars. Low blood sugar is life threatening. [Appx. 1, p. 12**b**]. Assuming that his blood sugar would have fallen because of the 15 units of insulin, Jack could have been saved with foods containing sugar. [Appx. 1, p. 12**b**]. He also could have been given an IV. Johnson took none of these rudimentary and, frankly, elementary actions according to her own nursing notes. Johnson failed to do a fall protocol, neurological protocol, or a head injury protocol. [Appx. 5, p. 81**b**; Appx 2 p. 12**b**; *Also see* Appx 21-23, pp. 144-149**b**].[20]

Landin reasonably concluded that Jack's death was caused or precipitated by the negligence of Johnson. He wrote his supervisor, Amber Boyk, a Variance and Concern Report

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[18] See Appx. 25, p. 151**b**. Landin testified that regular acting insulin takes two hours to reach peak efficacy. That is, the blood sugars would have dropped within two hours of the administration of the insulin. Landin went through a plethora of precautions of what he would have done had he been treating Jack. If the blood sugars were truly 515 then he would have checked on the patient hourly after the administration of the drug. [Appx. 1, p. 11**b**]. Not surprisingly, Johnson did not know peak efficacy times for insulin. [Appx. 5, p. 74**b**].

[19] Ms. Johnson admitted that LaShawnda Curry found Jack and that Curry called Johnson. She also admitted repeatedly how deficient her nursing notes were. Specifically, that there was no notation of calling PA Lindsay. It did not show when or if Jack was given the insulin. It did not document what she told Lindsay and what he told her. She did not document what follow up orders were given. She testified that she found no vomit with Jack when called by Curry but had to admit on cross-examination that there was vomit present. [Appx. 5, p. 72**b**-73**b**]. She further admitted she was supposed to know the history of her long term care patients. That was "very important". [Appx. 1, p. 14**b**]. Ms. Johnson, a person who had now been a nurse since 2004, did not even know what it meant to be a "brittle" diabetic. To her, "they were all" the same. [Appx. 5, p. 73**b**]. She admitted she did not know the term in 2006. [*Also see* Appx. 5, p. 74**b**].

[20] Johnson admitted that she did not take Jack's blood sugar after the CENA found him in a pool of vomit and diarrhea. She did not know what type of insulin Jack was getting. She did not know what it meant to be a brittle diabetic. She knew that low blood sugars are life threatening and sugars below 60 should be taken every 15 minutes. She didn't do that either. She committed a lifetime of errors on one night and did nothing except to let her patient die for a condition that was treatable with competent care. [*See* Appx. pp. 80-82**b**].

(V&CR) that documented his concerns. [Appx. 1, p. 13**b**].[21] Mr. Landin testified that he wrote the V&CR in good faith, and that he believed that Gayle Johnson was dangerous. He testified:

Q At the time you wrote this, Mr. Landin, did you write this in good faith?
A Yes.
Q Did you believe that the death of Jack could have been avoided if other remedial measures would have been taken?
A Absolutely.
Q Did you believe that Gayle Johnson was dangerous at that point?
A Yes.
Q As on this occasion, had you ever, in 23 plus years, ever written a report where you said a coworker had negligently contributed or precipitated, unintentionally, of course, to the death of a patient?
A No, sir, never have.
Q Why did you decide to write it on this event on that night?
A I didn't want another patient to suffer. I didn't want another patient that - - that this could happen to.
Q Did you believe that Gayle Johnson was competent at that point to be a nurse on that floor?
A She is not competent, sir. [Appx. 1, p. 13**b**].

Mr. Landin wrote the V&CR and slipped it under Boyk's door. He did not give it to a state agency nor did he threaten to give it to a state agency.[22] Prior to this time neither he nor Gayle Johnson had written each other up. Prior to this time Gayle Johnson had never written up anyone. [Appx. 1, pp. 13**b**-14**b**, *also see* Appx. 5, p. 85**b**; Appx. 570, p. 214**b**].

Immediately after Landin submitted the V&CR on Johnson, their relationship became strained. Johnson retaliated and wrote a report and informed Boyk that Landin was talking to the widow of Jack. [Appx 27 p. 153**b**]. Thereafter, Landin was immediately called down to Human Resources (HR). He met with Katie Adams, head of HR, and Boyk, Landin's direct supervisor. Both women wanted to know whether he was telling Jack's widow that he believed Johnson was

[21] The Variance and Concern Report directed to Boyk is admitted. See, Appx. 39, p. 180**a**.
[22] Because Landin did not report the suspected malpractice to a state agency, nor did he threaten to report it to a state agency/public body, he did not meet the requirements of having a claim pursuant to the WPA. See, MCLA 15.362 *et.seq.* Rather, he reported the malpractice to his supervisor as he was instructed to do in the chain of command.

responsible for the death of Jack. They asked if she planned on suing the hospital. [Appx. 1, p. 14**b**]. Adams and Boyk interrogated Landin on at least two (2), and possibly three (3) occasions, regarding his conversations with the Jack's widow. These were the only times that Landin had been called to HR during his employment. [Appx. 1, p 14-15**b**].

B. AMBER BOYK /GAYLE JOHNSON RETALIATE AGAINST LANDIN.

Landin had worked on the psych ward for almost four years and testified it was unsafe to deliver the medications, as per the policy. He had **never** been written up. [Appx. 1 p. 18**b**].

1. The Trilogy of Horrors Created by Amber Boyk and Gayle Johnson within One Week of Landin's Report to Boyk that Johnson's Incompetence Precipitated the Death of a Patient, and that she Posed a Danger to Healthsource Patients.

Within days of Landin's report that Johnson precipitated and/or caused the death of Jack, posed a danger to other Healthsource patients, and had been talking to the widow of Jack, he was written up at the suggestion of Gayle Johnson and was subsequently written up three times within a matter of a couple of months and terminated.

a. The First Event March 1, 2006, Less Than One Week After Landin's Variance and Concern Report.

There was a female patient, "Jean", a long-time resident, who was ambulatory and smoked. "Jean" often left her room. She came back to get narcotics. Landin admitted he did not give Jean her medications on that day. He did that because, based on long time treatment of her, he knew that Jean hoarded breathing medications in her drawer. He did not believe he was falsifying anything. [Appx. 1, p. 19**b**]. Jean told him not to worry about it. [Appx. 1, p. 19**b**].

The more telling significance of the complaint, however, is how it occurred. Landin explained that within one week of reporting Johnson, Gayle Johnson asked Jean and her husband

to file a complaint against him because Johnson felt if she reported the incident it would appear to be retaliation. [Appx. 1, p. 19**b**; Appx. 5, p. 93-94**b**; Appx. 30, p. 156**b**].

Appx. 30, p. 156**b** documents that Johnson had Jean and her husband file a complaint.[23] The document also suggested Mr. Landin said mean and nasty things to Jean. That was not true despite the fact that Jean often said nasty things to Mr. Landin because she wanted more narcotics and he could not give them to her. [Appx. 1, p. 19b]. The jury saw the relative demeanor of Mr. Landin, a no non-sense ex-military man, who answered, "yes sir" or " no sir". In the military Landin was trained to never say anything "nasty" to a patient. [Appx. 1, p. 19**b**].

b. March 2, 2006, Five Days After the Death of Jack, Gayle Johnson/Amber Boyk, Retaliate Against Landin Again.

On March 2, 2006 Gayle Johnson filled out a reporting Occurrence Worksheet on a patient named "Marjorie". [Appx. 31, p. 157-158**b**]. Marjorie, a long-time patient, was not in her room when Mr. Landin came to give medications. Marjorie had left her room to be with her daughter. It was a Wednesday night and Landin had school. He asked another nurse, Sue Erskine, a good friend of Gayle Johnson, to provide Marjorie her medications. Erskine promised that she would give the medications [Appx. 1, p. 20**b**]. The next day it was stated that Ms. Erskine did not give Marjorie her medications and Mr. Landin was written up. [Appx. 1, p. 20**b**]. Erskine refused to talk to Landin after he filed his V&CR against Johnson. Erskine was not written up. Who filed the Complaint against Landin? Gayle Johnson and supervisor Amber Boyk. [Appx. 1, p. 20**b**; Appx. 31, pp. 157-158**b**]. As a result of the two reports solicited by

[23] The document in Appx. 30, p. 156**b**, is the report of Irene Lowe based on the lies of Johnson. The only truthful thing in the document is that Johnson **solicited** the report and it is retaliatory.

Johnson/Boyk, Landin received a five (5) day suspension in a letter dated March 10, 2006. [Appx. 1, p. 20**b**; Appx 30, p. 159**a**] [See Appx. 22, pp. 146**a**-148**a**].[24]

c. After Landin Made the Variance and Concern Report to Amber Boyk, he was Treated as a Pariah.

Mr. Landin explained after he authored the V&CR, Appx. 39, p 180**a**, and gave it to Boyk, he was treated as a pariah. [Appx. 1, p. 20**b** see piranha rather than pariah]. He explained that people would no longer socialize with him. No one asked him to go out. He was ignored. People who were his friends no longer wanted anything to do with him. [Appx. 1, p. 20**b**].

d. The Third Complaint Against Landin that Alleged he did not give a Patient, "Scott" B., Epileptic Medications, and Allegedly Resulted in his Termination, was Contrived and Untrue.

On April 28, 2006 Mr. Landin was terminated. [Appx. 34, p. 163**a**]. He was terminated, allegedly, for his failure to give a resident, "Scott" B., his scheduled medications on April 23, 2006. Mr. Landin acknowledged being responsible for Scott at 900 and 1800 hours on April 23, 2006. In reviewing the chart, however, one can glean Landin's initials are recorded indicating the medication was given. [Appx. 1, p. 21**b;** Appx. 17 p. 136**b**]. Landin explained that he gave Scott his medications and Scott never had a seizure while Landin worked. [Appx. 1, p. 21**b**].

Mr. Landin also explained that in the past he had problems with Scott because he had short-term memory loss. [Appx. 1, p. 22**b**]. Ms. Boyk **admitted** that the patient's MAR demonstrated that Landin did give the patient the medication. [Appx. 17, p. 136**b**].

The allegation, however, was that the patient, who was mentally retarded, told Gayle Johnson that he did not get his medication and then had his medications actually found in the

[24] On the same day that Landin is suspended for the aforementioned offenses, Gayle Johnson, despite having it alleged that she killed or precipitated the death of Jack, failed to do 12/16 dressing changes, received a prior five day suspension in November of 2005, only received a group II offense for failing to give a medication and lying about it because, in the eyes of Amber Boyk, " there was no harmful intent" [*See* Appx. 37, p. 168**b**]. (Emphasis added).

medication cart.[25] Guess who found the medications? None other than Gayle Johnson. Boyk was asked, "Did that concern you"? And she responded "No". Notwithstanding her prior testimony that Gayle Johnson was "very angry at Mr. Landin" and that "Johnson had a temper". [Appx. 3, p. 56**b**].[26]

C. LANDIN PROVED THAT AMBER BOYK INTENTIONALLY CREATED DOCUMENTS TO AUGMENT HEALTHSOURCE'S PRETEXT TO TERMINATE LANDIN AND IMPAIR HIS LICENSE, ALL BECAUSE HE WROTE THE VARIANCE AND CONCERN REPORT ALLEGING THAT JOHNSON PRECIPITATED THE DEATH OF JACK AND POSED A CLEAR DANGER TO OTHER HEALTHSOURCE PATIENTS.

Landin has explained in the introduction, how Boyk set out on a mission to discredit, retaliate and terminate Landin. Counsel for the Appellee Landin has spent countless hours going through the documents. Suffice it to say, while counsel understands the interaction between the documents take some time to get familiar with, there is no doubt if the reader of the brief takes the time, he/she will fully understand that the only explanation for the documents found in Appx. 42, p 183**a**; Appx. 38, p. 179**a** is that Boyk made them up. [Sealed un-redacted copies are provided at Appx. 50, p. 195**b**; Appx. 51 p. 196b, Appx. 52 197b].

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[25] Scott was mentally retarded as demonstrated by his prior history. He had been hit in the head by a rock thrown by his brother when he was in his mid-teens. He developed epilepsy and a history of mental retardation. He was a person who had short-term memory loss. As Mr. Landin explained, "so you could talk to him and a half hour later, he forgot that he ever talked to you". [Appx. 1, p. 17**b**]

[26] The testimony of demonstrated that Scott's mother brought in bulk medications. [Appx. 1, pp. 16-17**b**]. Johnson followed Landin and had access to the bulk medication and easily put these medications in a cup and claimed that she found them. [Appx. 1, pp. 22-23**b**]. The Healthsource documents demonstrate, contrary to the claims of Johnson, that Landin did give Scott his bulk medication. [See Appx. 17, p. 136**b** with initials of RL on 4/23/06]. As Landin so astutely noted, he told Boyk, "...I had [given] the medication, but I said you know what, **I am getting set up here, I'm being set up**. That was my rebuttal to Amber". [Appx. 1, p. 23**b**].

The seminal, **and only**, event with Scott B. occurred on April 23, 2006. This is an event that was allegedly worthy of termination. However, there is no history of even so much as a verbal warning regarding any alleged similar event.

The date of the event with Scott B was, initially, incorrectly documented by Gayle Johnson as April 23, 2004. Everyone admits that was an error. Amber Boyk admitted that Johnson "did not even write the date down correctly". Boyk knew that the correct date is April 23, 2006, and the event is the final event before Landin is terminated. [Appx. 3. pp. 54-55**b**].

The deceased nurse Pettelle, could not have written about this event in her alleged message to Boyk on February 26, 2006, the day after Landin's report to Boyk about Johnson. [Appx. 29, p. 155**b**; Appx 51 p. 196**b**]. The reason being that on February 26, 2006, the event that allegedly occurred with Scott B had not yet occurred for another two months.

A careful review of Appx. 29, p. 155**b** and Appx. 42, p. 183**a**, with the foundation that an error had been made on Appx. 50, p. 195**b**, dating the event 4/23/04 as opposed to the actual date 4/23/06, is critical. Appx. 29, p. 155**b** purports to be an email or letter from Pettelle to Boyk that clearly refers to events that occur two months after this email/message is sent. The document created by Boyk, in the name of Pettelle, makes specific reference to Landin retaliating against Johnson for being **"written up"** for not passing a group of medications to Mr. B. [Scott]. [Appx. 29, p. 155**b**]. Pettelle allegedly puts the word "**written**" up in quotes. There is, of course, only one time that Landin was written up for not giving Scott B. his medications. That is on 4/23/06 two months after Pettelle allegedly wrote the document that we now know was written by Boyk.

One knows that Boyk had to have manufactured the documents by referring to her own corresponding diary notes. Appx. 42, p. 183**a**; Appx 52, p. 197**b**. is a note that is alleged to be

made by Boyk starting on February 27, 2006 and ending on February 28, 2006. Sandwiched in the middle of that document is reference to finding "pills in the medicine cart [Scott B.] on it (cup)". That is the event that the Plaintiff was allegedly fired for and that event did not occur for another two months, or April 23, 2006. Boyk made an error using the erroneous date on Appx. 50, p. 195**b**. She then created both of these documents to support the decision to terminate Landin. Healthsource meticulously went through every verbal warning and/or "write-up" of Landin. There is no other "**write-up**" concerning Scott B. There is no other "documented" event where Landin made a report on another nurse. There is no doubt that Boyk fabricated Appx. 29, p. 155**b** (Appx. 51, p. 196**b**) and Appx. 42, p. 183**a** (Appx. 52, p. 197**b**).[27]

D. EVIDENCE OF DISPARATE TREATMENT AND RETALIATORY ANIMUS BY HEALTHSOURCE.

It is difficult to describe the disparity in care provided by the Landin, and Gayle Johnson. During the oral argument at the Defendant's Motion for Judgment Notwithstanding the Verdict, Judge Boes noted, "I did not think that Gayle Johnson came across as knowledgeable or competent. **In fact, she seemed to have a startling, if not appalling, lack of knowledge.**" [Appx. 56, pp. 211-212**b**]. [Emphasis Added].

1. Gayle Johnson's Errors Prior to February 2006.

On October 25, 2005 Johnson got a written counseling for her fifth unscheduled absence [Appx. 38, p. 169**b**].[28] On November 30, 2005, Johnson was given a Group I suspension. [Appx. 35, p. 166**b**].[29] Shortly thereafter Johnson was issued a V&CR written by Deb Wilson

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[27] Pages 195b, 196b, and 197b are the un-redacted sealed versions of the documents.

[28] Boyk stated attendance was part of being a "good" nurse. Johnson was written up for attendance issues every year from 2005-2009. [Appx. 3, p. 38**b**; Appx. 38-41, pp. 169-172**b**].

[29] Interestingly, there is no explanation for the three-day suspension. Boyk could not remember. But it did not detract from her opinion that Johnson was a "**good**" nurse. [Appx. 3, p. 36**b**]. [Emphasis added].

confirming that Johnson failed to do dressing changes, failed to treat necrotic sores on a severely diabetic patient on "numerous" occasions. [Appx. 55, p. 210**b**]. It stated Johnson "continues to ignore the importance of changing the dressings twice a day" [Appx. 55, p. 210**b** (emphasis added)]. Despite this Boyk's opinion was that Johnson was a "good nurse". [Appx. 3, p. 36**b**].

On January 31, 2006, Dale Pettelle, the RN in charge of Nurse Supervision, did actually author a coaching on Johnson before Pettelle's untimely demise in October 2008. [Appx. 3, p. 37**b**; Appx. 36, p. 167**b**]. Ms. Pettelle noted that Johnson's peers reported that she was remiss in completing her tasks dealing with dressing changes on "brittle" diabetics. The document confirmed that Johnson failed to do 12 out of 16 dressing changes because "she had a large load and could not get to it". [Appx. 36, p. 167**b**]. Worse, not only did Johnson fail to perform the procedures, she failed to arrange for another nurse to do it. Nurse Pettelle noted that as a result it could lead to a patient "going septic or even expire from septicemia or amputation et al". [Appx. 36, p. 167**b**]. In a prophetic statement Dale Pettelle coached as follows:

> ...Also explained that her continuing to complete tasks (sic) because her "load is too heavy or she is tired" ultimately can lead to problems with her PIR, licensure, survey results, and progressive disciplinary responses. She will be transferring to a single nurse unit by 06 February and oversight is not as frequent, but the need to maintain appropriate response to patient needs is just as prescient and prioritizing is just as critical" [Appx. 36, p. 167**b**][30]

Boyk stated that this event did not detract from her opinion that Johnson was a "good" nurse. Appx. 36, p. 167**b**; Appx. 3, p. 37**b**. Boyk admitted that each failure to perform one of the aforementioned dressing changes in Appx. 36, p. 167**b** constituted the **highest level** of misconduct pursuant to the Discipline Policy, Appx. 22, pp. 146-148**a**. A group 1 violation is

[30] The warning was ever so prescient as Johnson's inability to prioritize was probably the cause and/or precipitating factor of Jack's death just as reported by Landin. Nevertheless, it was Johnson's opinion that Pettelle and others moved her because the "nurses was picking on me like I never did anything right. I didn't have no support of a nurse that actually worked with me. They was always—and it stopped and they wasn't a mentor, so she felt that it would benefit me working on a single unit." [Appx. 5, p. 91**b**][emphasis added].

supposed to, at a minimum, result in a three-day suspension. [Appx. 3, p. 37**b**].[31] Boyk confirmed that these failures constituted a Group I violation. [Appx. 3, p. 38**b**]. The Nurse Executive Susan Graham also confirmed that. [Appx. 7, p. 122**b**]. Boyk said that she knew Johnson would have to improve her prioritization but that when she was moved in February 2006 she went from a nurse who had some problems to a "good" nurse. [Appx. 3, p. 38**b**].

2. LPN Johnson Committed No Less than Twenty (20) Group I Violations in Relation to the Treatment of Healthsource Patient Jack, Who Upon Information and Belief Passed Away as a Result, and Johnson did not even Receive a Write up.

Objectively, Gayle Johnson committed more errors, on one night, than some nurses may commit in a career. Appellant's assertion that Landin made "false allegations regarding co-worker Johnson" is the epitome of unbridled arrogance. [See, Appellant's br. p. 18]. Johnson, for the most part, admits each error, not to mention the prior dressings errors that caused her to be kicked off the "skilled floor". In admitting those errors her explanation was that she was "too busy" and that even she admitted that Landin was a "**gooder**" nurse than she. Appx. 5, p. 85b.

A review of the errors committed by Johnson is truly mind-boggling. A synopsis of Healthsource's Administration of Medications Policy is found in Appx. 21, pp. 141-145**a**. The policy regarding "Physician Orders" is found in Appx. 8, p. 137**b**. The policies, together, mandate that verbal orders are to be avoided and given only in emergencies. [Appx. 3, p. 39**b**]. Written orders are much safer. [Appx. 1, p. 10**b**; Appx. 3, p. 39**b**]. When taking a verbal order it **must** be an emergency in the eyes of the nurse and the doctor and the nurse **must** write down

[31] Pursuant to Appx. 22, pp. 146-148**a** Work Rules a Group 1 violation includes: I. (13) "Failure to fulfill job responsibilities to the extent that such failure has the potential for or does cause injury to a person or substantial damage to equipment or to HHS. Failure to fulfill job responsibilities will include neglect of any patient, resident or client. Neglect is failure to provide ... services necessary to avoid physical harm, mental anguish or mental illness". According to Appx. 22, pp. 146-148**a** Group 1 (13) Johnson could have been fired or suspended for each failure to change dressings as required. Each failure constituted neglect.

exactly what the doctor orders, and what the nurse tells the doctor. [Appx. 1, pp. 10-11**b**; Appx. 3, pp. 39-40**b**]. Johnson clearly violated both of these Healthsource edicts.[32] Johnson admitted that she failed to properly chart her nursing notes that she gave Jack 15 units of insulin on the night of February 24, 2006. She also acknowledged that she was required to write down what she told P.A. Lindsay and what he told her. [Appx. 5, p. 72**b**; Appx. 5, p. 74**b**; Appx. 5, p. 80**b**]. She failed to write what time she gave the insulin. [Appx. 5, p. 73**b**]. Johnson admitted there is no record of her checking on Jack in the 4-½ hours between the time he was given insulin and the time he was found on the floor in a pool of vomit and diarrhea. [Appx. 5, p. 80**b**].

Incredibly Johnson admitted that when Jack was found in vomit and diarrhea she had the CENA clean him up but she did not take his vitals.[33] She left that to the CENA once she cleaned him up. She never had his blood sugars tested after the time he was found on the floor. [Appx. 5, p. 81**b**]. Johnson was **not** aware a person with very high blood sugars could then swing very low after the administration of 15 units of insulin and was not sure if finding someone on the floor, covered with vomit and diarrhea, was consistent with low blood sugars. [Appx. 5, p. 81**b**].

Johnson agreed with Boyk and Landin that with long-term patients it is very important to know the resident's history. [Appx. 5, p. 73**b**]. Even after two years of employment as a LPN Johnson did not know what a "brittle" diabetic meant. [Appx. 5, p. 73**b**].[34] Incredibly she did not

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[32] Indeed, at the time Johnson did not even understand that verbal orders were to be avoided. [Appx. 5, p. 79**b**]. When asked what concerns Johnson had her answer was that Jack's sugars were "out of whack". When asked, as a result of "out of whack" sugars what medical concerns she had and her answer was that she had no concerns. [Appx. 5, p. 79**b**]. She did not remember what PA Lindsay asked her and did not know what she told him. [Appx. 5, pp. 79-80**b**].

[33] In her deposition that she was repeatedly impeached, Johnson did not know what was more important, cleaning up Jack or taking his blood sugars where he was a brittle diabetic who had a blood sugar of 515, was given 15 units of insulin, and then was found dazed and confused in a pool of vomit and diarrhea. [Appx. 5, p. 82**b**]. Johnson explained that she got sidetracked taking care of other patients and never got back to Jack to take his blood sugars. [Appx. 5, pp. 82-84**b**].

[34] All the more frightening since Johnson was written up by Pettelle, a month before Jack's death, because she failed to take care of those "brittle" diabetics necrotic sores. [See Appx. 36, p. 167**b**]

know the workings of insulin nor did she know when the insulin reached max effect. [Appx. 5, p. 74**b**; Appx. 5, p. 81**b**].

Appx. 20, p. 142**b** provided the protocols for fall prevention. Johnson knew that Jack fell out of bed as he was found on the floor and not ambulatory. In such a circumstance a nurse is to write a fall report/neurological report. [Appx. 3, p. 42**b**]. Johnson failed to author a fall report on Jack. [Appx. 5, p. 81**b**]. She likewise failed to do a neurological or head injury report.

When Jack was found on the ground Johnson should have called the PA who ordered the insulin. She did not make that call. [Appx. 5, p. 74**b**]. In addition because there was a fall she was suppose to put an episodic charting notation on his file. Johnson failed to do that because "she didn't get a chance to". [Appx. 5, p. 89**b**; Appx. 23, pp. 148-149**b**; Appx. 3, p. 43**b**].

On the prior evening Johnson did not take a second blood sugar when Jack's blood sugars read 515.[35] She acknowledged that there are false readings. [Appx. 3, p. 53**b**]. She agreed that a 515 sugar should have gone in the progress notes and that she failed to do it. [Appx. 5, p. 77**b**].

Johnson admitted that between the time she gave the 15 units of insulin and the time he was found on the floor at 1:30 am that she never checked on him. She never checked on him because she had 34 other patients and she was **"too busy"**. [Appx. 5, p. 89**b**]. She also acknowledged that when the CENA found Jack on the floor at 1:30 a.m. in a pool of vomit and diarrhea, she did not take his blood sugars. [Appx. 5, p. 81**b**] She admitted that low blood sugars are dangerous and life threatening. If a blood sugar is below 60 they are to give the person orange juice. If it is below 40 one can die. [Appx. 5, p. 76**b**].

The report that Dale Pettelle did actually write when Johnson was removed from the "skilled floor" for neglect and incompetence was truly prescient: She warned as follows:

[35] She also admitted that being a "new" nurse, having only passed her exams two years before, she did not understand a sliding scale and in three months she had not taken the time to learn Jack's history. [Appx. 5, p. 78**b**].

"Ms Johnson, as reported by her peers, has been remiss in completing her tasks dealing with dressing changes… This issue what was discussed with Ms. Johnson tonight. She stated that she has a large load and sometimes cannot seem to get to it. Explained, that based on the treatment sheet, she has not done it 12 out of 16 times she had this resident. Further, it by NOT doing this and or arranging for it to be done, it can lead to such a patient going septic or even expire from septicemia or amputation… Therefore, It is mandate (sic) did she prioritize her time in an effort to assure her treatments are completed either by herself or one of her peers…

* * *

"Also, explained this her continuing to complete her tasks because her load is too heavy or she is tired ultimately lead to problems with her PIR, licensure, Survey results, and progressive disciplinary responses. She will be transferring to a single nurse unit by 06 February 2006 and oversight is not is frequent, but the need to maintain appropriate responses to patient needs is just is prescient in prioritizing is just as critical.
[Appx. 36 p. 167**b** (dated 1/31/06 merely twenty-five days before she precipitated the death of Jack)].

Landin's report that Johnson caused or precipitated the death of "Jack" and posed a danger to other Healthsource patients was not "false" as argued by Appellant. Rather, Landin was spot on, as was Pettelle. Johnson was not a good nurse and posed a danger to patients.

3. Roberto Landin's Minor Infractions Compared to Johnson and Disparate Treatment.

a. Defendant Meticulously Admitted Each Infraction The Plaintiff Committed Before He Authored the Variance and Concern Report Regarding the Death of the Healthsource Patient, Jack, and there was No Evidence of a "Write-Up" Regarding the Failure to Pass Medications to "Scott" prior to April 23, 2006.

Defendant meticulously admitted every instance wherein the Plaintiff did anything wrong, whether he did it or not, and whether it occurred at Healthsource or other facilities. [Appx. 1, p. 27**b**]. Whenever there was any documentation the Defendant admitted the exhibit. The Defendant's allegations were as follows for the years 2001-February 25, 2006:

1. That over his many years at Healthsource Landin did not blindly follow his supervisors when he believed their judgment was incorrect and questioned a few supervisors over the course of his employment who he believed had exhibited poor judgment, i.e. having less trained nurses do CPR etc… that is he questioned their judgment when he thought that they were incorrect; [Appx. 15, pp. 89-90**a**];

Boyk testified at trial that Johnson was a "fair" employee and Landin was a poor employee. She was impeached with deposition testimony wherein she graded Johnson as a "**good**" employee. [Appx. 3, pp. 34-35**b**].[37]

Appx. 22, pp. 146-148**a** was admitted by Boyk to be an ambiguous document that allowed Healthsource to modify its rules to fit whatever purpose Healthsource desired. [Appx. 3, p. 39**b**]. The policy allowed Healthsource to do whatever it wanted, even if it was for an unlawful reason. [Appx. 3, p. 39**b**]. Specifically Ms. Boyk was asked as follows:

> "Q. …The policy allows them, for whatever their motives or wants are, they can change the policy to fit whatever the want to do; fair to say?
> "A. Per the policy, yes.
> "Q. There is no mandatory—you could, as an extreme, you could absolutely go out and kill somebody, and that policy doesn't demand that they fire you, true?
> "A. Not with the wording of the policy.
> "Q. Right. And there is no limit under the policy how many Group I violations you could get. We know that she [Gayle Johnson] got 12 and she didn't get written up, fair to say?
> "A. Yes. [Appx. 3, p. 39**b**].

Boyk admitted that the rules are written in such a way that allows them to retaliate, or get rid of those employees that they don't want. [Appx. 3, p. 42**b**].

a. Weeks Before Landin is Terminated Johnson committed the Identical Infraction that Landin was Alleged to do, then Lied About it, and Despite her Prior Record of Failing to Give 12/16 Dressing Changes, and Evidence that she had just Caused or Precipitated the Death of Jack, Johnson is Given a Group II Violation by Boyk Because there was "No Evidence of Malicious Intent".

A prime example of how ambiguous the Healthsource Policy on Discipline was, and how it was used in a disparate manner against Landin, is demonstrated in Appx. 37, p. 168**b**. Ms. Boyk admitted that medication errors at Healthsource are common. [Appx 3. p. 44**b**]. On March 6, 2006, Johnson, the same day Boyk is writing up Landin, was accused of falsely telling a

[37] Not only was evidence of Johnson admissible to prove that Landin had a good faith belief that she was negligent, it was also admissible to impeach Boyk.

supervisor that she administered drugs but upon review it was discovered that she did not document the treatment. Appx. 37, p. 168**b** is a written warning for an offense that was admitted to be the same as what Landin was accused of doing. The relevant colloquy was as follows:

> "Q. Now whether the medication error is signing your initials when you didn't give the medication or not signing after, you were suppose to write them up, (sic) is that true?
> "A. Yes, education or write-up or depending on where in the policy or where in the discipline they are at?
> "Q. Yeah. Previously you said you looked at them as the same, correct?
> "A. Correct.[38] [Appx. 3, p. 44**b**].

Boyk testified she talked to Johnson and investigated Jack's death. That was contrary to Johnson's testimony at her deposition. The relevant colloquy was as follows:

> "Q. I asked you on line 19 at page 30: Were you called in to any meetings to discuss the circumstances of … Jack's death? And your answer was?
> "A. This answer right here is no.
> "Q. Your answer was no. Correct?
> "A. Right.
> "Q. Then I asked you: Human resources or risk management never called you in for any meeting regarding the death of Jack? And your answer was?
> "A. No." [Appx. 5, p. 75**b**].

Incredibly, despite a career of errors in one night, Johnson did not have her statement taken by HR, Risk Management or any other entity in Healthsource. She was never written up or given any discipline. [Appx 5, p. 75, 88, 89**b**]. Johnson denied ever talking to Boyk regarding any of the charges Landin made against her. [App. 5, p. 89**b**].

Boyk's statement that Johnson was a "good" nurse and was better than Landin, a "poor" nurse, was totally discredited. Even Gayle Johnson acknowledged that Landin was more knowledgeable than she was and a better nurse. The colloquy was as follows:

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[38] Boyk went on to say that the nurse's intent was not important because she would not know it. Later, however, in Appx. 37, p. 168**b** she coaches Johnson because she has no bad intent. Boyk, however, terminates Landin where he stated that he signed his initials and gave the medications to Scott B. [Appx. 3, p. 44**b**]. The record showed that Landin gave the medication but he was still fired. [See Medication Record Scott B, Appx. 17, p. 136**b**].

Q. Now you would agree that in 2006 and even in 2009, you believed that Mr. Landin was a more knowledgeable nurse than you were?
A. Well, he was a gooder (sic) nurse for years. Yes I would say he was knowledgeable.
Q. And he was more knowledgeable regarding the specifics of Jack, because he had treated him for a year of more?
"A. Yes
[Appx. 5, p. 85b].[39]

ARGUMENT I

MICHIGAN PUBLIC POLICY, AS DEMONSTRATED BY EXPLICIT LEGISLATIVE STATEMENTS IN THE PUBLIC HEALTH CODE, THE MICHIGAN CONSTITUTION, THE REGULATORY FRAMEWORK OF THE MICHIGAN ADMINISTRATIVE CODE THAT INCORPORATES A NURSE'S CODE OF PROFESSIONAL RESPONSIBILITY INTO A REGULATORY SCHEME, AS WELL AS THE COMMON LAW, PROHIBITS A HOSPITAL FROM DISCHARGING A NURSE IN RETALIATION FOR THE NURSE REPORTING TO HIS/HER SUPERVISOR THAT ANOTHER NURSE NEGLIGENTLY KILLED OR PRECIPITATED THE DEATH OF A PATIENT, AND THAT THE REPORTING NURSE FEARED THAT THE INCOMPETENT NURSE POSED A CLEAR DANGER TO OTHER PATIENTS IN THE HOSPITAL.

A. STANDARD OF REVIEW:

This Court reviews the trial court's proper denial of the Appellant's motions for summary disposition *de novo*. Also, questions of public policy are questions of law that are reviewed *de novo*. *Kelly v. Builders Square Inc.*, 465 Mich 29, 34, 632 NW2d 912 (2001).

B. THE PUBLIC POLICY EXCEPTION TO AT-WILL EMPLOYMENT IN MICHIGAN.

In *Suchodolski v Michigan Consol. Gas Co.* 412 Mich 692, 316 NW 2d 710 (Mich 1982), the Court recognized three public policy exceptions to Michigan's general rule of employment at will. According to *Suchodolski*, an employer is not free to discharge an employee (1) when such discharge runs contrary to "explicit legislative statements prohibiting the discharge . . . of employees who act in accordance with a statutory right or duty" (2) "where the alleged reason

[39] After denying before that she was "angry", Johnson admitted "you'd be angry, too" if someone accused you of killing somebody. She knew Landin thought her work was "substandard". After denying she was angry Johnson stated she was angry for being called dumb and substandard. [Appx. 5, p. 86b]. [Emphasis added]. The most appropriate word describing Johnson was the word used by Mr. Landin, "dangerous". [*See* Appx. 39, p. 180a].

for the discharge of the employee was the failure or refusal to violate a law in the course of employment" or (3) "when the reason for a discharge was the employee's exercise of a right conferred by a well established legislative enactment." *Id.* at 695-96, 316 NW 2d at 711-12.

Twenty years after *Suchodolski*, the Court in *Terrien v. Zwit*, 467 Mich 56, 648 NW2d 602 (2002), held that a covenant banning a licensed family day care home in a residential neighborhood, pursuant to MCL 722.111, was enforceable and did not violate public policy.

Terrien, contrary to the Appellant's assertion, is consistent with the three exceptions provided in *Suchodolski.* The Court's decision in *Terrien* did not result in a curtailment of public policy law.[40] Rather, the Court in *Terrien* clarified the paths in which public policy can be gleaned. None of the public policy exceptions set forth in *Suchodolski,* existed in *Terrien.* In *Terrien*, unlike this case, there was no legislative enactment, administrative rules, common law precedent, constitutional statements, nor were there professional guidelines that provided the foundation for the public policy herein. Consequently, the covenant in *Terrien* to exclude a license day care home was enforceable and did not violate public policy.[41]

Justice Markman, writing for the majority, declared:

> "To determine whether the covenant at issue runs afoul of the public policy of the state, it is first necessary to discuss how a court ascertains the public policy of the state. In defining "public policy," it is clear to us that this term must be more than a different nomenclature for describing the personal preferences of individual judges, for the proper exercise of the judicial power is to determine from objective legal sources what public

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[40] The Court explained, "[t]he dissent asserts that the majority opinion "eviscerates the public policy doctrine" and is "contrary to this to this Court's long established practice." Post @ 617, 621. "**Once more we disagree**. This opinion merely sets forth the unexceptional proposition that an assertion of public policy as a basis for nullifying a contract must, in fact, be grounded in public policy". [*Terrien supra* @ 78]. (Emphasis added).

[41] The Appellant's statement that the court of appeals' decision in this case "by using its own discretion has *defacto* overruled *Terrien"* is indicative of the type of inaccurate hyperbole used throughout the Appellant's brief. [See Appellant's brief. p. 23]. In this case the court of appeals specifically addressed *Terrien* and explained how, and why, its decision was consistent with not only *Terrien*, but also with *Suchodolski* and its progeny.

> policy *is*, and not to simply assert what such policy *ought* to be on the basis of the subjective views of individual judges. *Terrien supra* @ p. 66 (footnote omitted).

What the *Terrien* Court did provide, however, was a more detailed road map as to how one determines what constitutes public policy. The Court reasoned:

> "In identifying the boundaries of public policy the focus of the judiciary must ultimately be upon the policies that, in fact, have been adopted by the public through our various legal processes, **and are reflected in our state and federal constitutions, our statutes and our common law**". *Terrien supra* pp. 66-67 (fn omitted) *citing Twin City Pipe Line Co. v. Harding Glass Co.*, 283 U.S. 353, 357; 51 S. Ct. 476, (1931). (emphasis added).[42]

Moreover, the Court opined that what was missing from the defendant's argument in *Terrien* is some "definitive indication" that to exclude "family day care homes" from an area was incompatible with the law. The Court announced, "[t]here is a significant distinction between something being permitted or even encouraged by law and something being required or prohibited by law". [*Terrien supra* @ p. 69]. The Court further stated, as argued by the Appellant, "the public policy of Michigan is not merely the equivalent of the personal preferences of the majority of this Court; rather such a policy must ultimately be clearly rooted in the law", *Terrien supra* @ p. 67. What the Appellant failed to include in its brief, however, was the footnote that went along with that paragraph. The Court declared:

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[42] Appellant claims that the court of appeals decision violates the rule of *Smith v. Globe Life, 460* Mich 446; 597 NW2d 28 (1999) prohibiting the provision of a "creative label" to circumvent the legislature's intent. [Appellant's br. p. 23]. *Globe Life*, however, is not analogous to this case. Rather, *Globe* involved the voiding of an insurance contract because the insured perpetrated a fraud on the insurance company by making misrepresentations in his health application and a claim under Consumers Protection Act, MCL 445.911 *et seq*. There is no applicable public policy claim in *Globe*, and no indication as to how *Globe* is relevant to this case. Likewise, Appellant urges this Court that *Henry v. Dow Chem Co.*, 473 Mich 63; 701 NW2d 684 (2005) dictates that this Court should not go to areas "better left to the legislature". [Appellant's br. p. 43]. *Henry* is not applicable to this case as the Legislature herein, through various statements, has demonstrated a strong desire to protect the public from incompetent medical care. In *Henry*, the plaintiffs wanted the Court to declare a change the common law of negligence and provide for a recovery for "future injuries". The Court noted that historically a plaintiff had to show an injury to proceed in a negligence action. *Henry* is not applicable to this case.

> **"We note that, besides constitutions, statutes, and the common law, administrative rules and regulations, and public rules of professional conduct may also constitute definitive indicators of public policy"**. *Terrien supra*, FN 11, p. 67, (Emphasis Added).

The *Terrien* Court found that there was a "missing link" in that case. The Court found "no definite indication of the law of Michigan to justify the invalidation of a covenant precluding the operation of a family day care homes". [Id @ 68]. That resulted in the Court finding that the exclusion of the day care facilities was merely "the personal preference" of a judge, and therefore, was not the public policy of the State of Michigan. [*See*, *Terrien supra* @. 66].

There is no "missing link" in this case. Rather, when viewed in context of the Court's directive that public policy be discerned by reference to "**constitutions, statutes, ... the common law, administrative rules and regulations, and public rules of professional conduct**" the evolutionary path to the determination that public policy was breached in this case is based on policy firmly entrenched in the law. [Id @ 67].

Landin's conduct is protected. His report that Johnson's negligence killed Jack, and posed a danger to Healthsource patients, is rooted in Michigan law and legislative enactments. The protection is specifically set-forth in the Public Health Code MCL 333.20176a, as addressed by the Court of Appeals and the trial court. However, public policy is also evident in other authoritative sources recognized by the Court in *Terrien*, such as the Michigan Constitution, The Rules of Professional Conduct governing the duties and obligations of nurses, the Michigan Adm. Code that incorporate a nurse's professional responsibilities, and the common law. All are identified by *Terrien* as capable of defining public policy. The decision below is not the reflections of amorphous personal preferences. There is no "missing link" in this case.

1. The Public Health Code and the Michigan Constitution Provide Direct Evidence of the Legislative Branch's Intention to Protect the Public Health.

This case is the quintessential example of a public policy claim. The protection of the public health, safety and welfare is the pre-eminent goal of any legislative body. In Michigan, this overriding concern is first addressed in the Michigan Constitution. Article 4 §51 provides:

> "The public health and general welfare of the people of the state are **hereby declared to be matters of primary public concern**...."
> Const 1963 Art 4 §51 (Emphasis Added).

Consistent with the Constitutional mandate, the Legislature of this State enacted the Public Health Code (PHC) MCL 333.1101 *et. seq.* as well as Administrative Rules and Regulations for Nursing [See, R. 338.10101 (*see infra*)]. The intent of the Legislature in enacting the PHC could not be any clearer when questions of health, and welfare are presented and where legislative construction may be necessary. Specifically, MCL 333.1111 provides:

> **(2) This code shall be liberally construed for the protection of the health, safety, and welfare of the people of this state**.[43] [Emphasis Added].

In interpreting a statute, this Court must attempt to ascertain the intent of the Legislature, considering the purpose of the statute in question. Statutes are to be construed so as to avoid absurd results and in the way most beneficial to the public. *Hill v. Highland Park General Hospital citing*, 80 Mich App 334, 263 NW2d 363 (1977).

Likewise, the purpose of the PHC is to protect and promote the public health, safety, and welfare and is designed to protect the public from incompetence, deception, and fraud; in order to effectuate those goals, the code must be liberally construed.[44] *People v Ham-Ying* 142 Mich

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[43] The mandate for liberal construction to effectuate public safety health and/or welfare is not a judicially created interpretation. In issues dealing with public health, the Legislature has mandated that all construction should be liberally construed to effectuate that goal.

[44] The incompetence of nurse Johnson is frightening. In one night, regarding one patient, she committed a lifetime of errors. Her history also documented so many errors that nurses on the skilled floor had her removed. In the words of the trial judge Janet Boes, "...I did not think Gayle Johnson came across as knowledgeable or competent. In fact, she seemed to have a startling if not appalling, lack of knowledge". Appx. 56 p. 212**b** (emphasis added). Public

App 831, 371 NW2d 874, *app den* (1985) 424 Mich 861, *later proceeding People v. Ham-Ying*, 178 Mich. App. 601, 444 N.W.2d 529, 1989 Mich. App. LEXIS 429 (Mich. Ct. App. 1989).

Seeming inconsistencies in the various provisions of a statute should be reconciled, if possible, so as to arrive at a meaning which gives effect to all parts of the statute; a construction leading to an absurd consequence should be avoided, *Attorney General v Ankersen*, 148 Mich App 524, 554; 385 NW2d 658 (1986).[45]

In construing the provisions of the PHC, and the public policy of the State of Michigan, it is evident the Legislature intended, consistent with the Michigan Constitution, that 1) Public health is of primary importance; and 2) The Public Health Code must be interpreted liberally to ensure that the goal of protecting the public health, safety, and welfare is guaranteed.

One of many legislative foundations for public policy that was violated in this case is found in MCL 333.20176(a). It provides:

"Sec. 20176a. (1) **A health facility or agency shall not discharge or discipline,**

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policy, the PHC, and the other sources of public policy are intended to protect the public from this type of incompetence.

[45] Appellant now argues, for the first time, that the legislative history of MCL 21076a cannot support a claim for wrongful discharge in violation of public policy. [Appellant's brief pp. 38-39]. Appellant cites House Legislative Analysis, providing parts of two different documents that are drafted by "non-partisan house staff". *See, Anthony v Michigan*, 35 F. Supp.2d 989 [ED MI 1999]. This Court has made clear that "in Michigan, a legislative analysis is a feeble indicator of legislative intent and is therefore a generally unpersuasive tool of statutory construction." *Frank W Lynch & Co v Flex Technologies, Inc*, 463 Mich. 578, 587; 624 N.W.2d 180 (2001). Legislative histories are free to be created by special interest pleaders and legislative staffers. *Id.* Because of the risk a court may rely on the dubious authenticity of the analysis, even the analyses themselves carry a warning "that they do not constitute an official statement of legislative intent." *Id.*, at 587 n 7. Moreover, These staff analyses are entitled to little judicial consideration in resolving ambiguous statutory provisions because: (1) such analyses are not an official form of legislative record in Michigan, (2) such analyses do not purport to represent the views of legislators, individually or collectively but merely to set forth the views of professional staff offices situated within the legislative branch, and (3) such analyses are produced outside the boundaries of the legislative process as defined in the Michigan Constitution, and which is a prerequisite for the enactment of a law. (citations omitted) *Morales v. Mich Parole Bd 260 Mich App 29, pp. 43-44; 676 N.W.2d 221 (2003).*

> **threaten to discharge or discipline, or otherwise discriminate against an employee regarding the employee's compensation, terms, conditions, location, or privileges of employment because the employee or an individual acting on behalf of the employee does either or both of the following:**
>
> (b) **In good faith reports or intends to report, verbally or in writing, the malpractice of a health professional or a violation of this article,** article 7, or article 15 or a rule promulgated under this article, article 7, or article 15.... [Emphasis Added].[46]

The legislative policy is clear. An employer may not discharge, discipline, or otherwise discriminate/retaliate against an employee who in good faith reported the malpractice of a health professional. That is a mirror image of what occurred in this case.

Healthsource asserts that the trial judge/Court of Appeals, "created public policy" in the "absence of a Legislative act or statute" in this case. [Appellant Brief on Appeal p. 1]. However, neither the trial court nor the court of appeals drafted, MCL 333.20176(a), other portions of the Public Health Code, the Michigan Constitution, the codes of professional responsibility as they are subsumed within the Michigan Adm. Code.

On its face, section 333.20176(a) meets prongs 1 and 3 of the *Suchodolski's* public policy exceptions. That is, (1) the discharge runs contrary to "explicit legislative statements prohibiting the discharge", and (3) when the reason for a discharge was an employee's exercise of a right conferred by a well-established legislative enactment. *Suchodolski supra*, @ 695-96; 316 NW2d @ 711-712. In *Terrien*, there was no such statement of legislative expression.

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[46] Landin reported in writing to Boyk the malpractice of Johnson. There is no requirement, for public policy purposes, that the "malpractice" be reported to a "public body". Moreover, hospitals, such as Healthsource, encourage that reports be made to supervisors. Landin did what he was supposed to do. Most nurses who report malpractice or incompetence of co-workers will report internally as to allow the employer to take appropriate remedial action. Finding that this rudimentary process is not protected, will have a chilling effect on nurses and/or on other medical professional and concomitantly will undermine the public health in Michigan.

2. Consistent with this Court's Holding in *Terrien v. Zwit*, there is Ample Evidence of Legislative Intent in the Nurses Code of Ethics, as Incorporated into the Michigan Administrative Code Regulating the Licensing of Nurses, to Support a Public Policy Claim in this Case.

a. *Rules of Professional Conduct as Indicators of Public Policy in Michigan.*

A nurse as a professional employee may confront circumstances where the nurse's professional obligations to his/her profession conflict with the responsibilities of an employee to obey an employer's directive. Frank J. Cavico and Nancy M. Cavico, Employment At Will, Public Policy, and the Nursing Profession, 8 Quinnipiac Health L. J. 161, 162 (2005)

The Code of Ethics for Nurses, with Interpretive Statements, promulgated by the American Nurses Association (ANA) is the standard for defining a nurse's professional obligations. [*Cavico & Cavico*, pp. 216-217 *citing* ANA Code of Ethics]. The ANA Code provides the following mandates

> "1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems;
> "2. The nurse's **primary commitment is to the patient**, whether an individual, family, group or community;
> "3. The **nurse promotes, advocates for, and strives to protect the health, safety and rights of the patient**;
> * * *
> "5. The **nurse owes the same duties** to self as to others, including the duty, to maintain confidence, and to continue personal and professional growth;
> "6. The nurse participates in establishing, maintaining **and improving healthcare environments and conditions of employment conducive to the provision of quality healthcare and consistent with the values of the professions through individual and collective action**;
> * * *
> "9. The profession of nursing, as represented by associations and their members, is **responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy**"
> ANA Code of Ethics, Code of Ethics for Nurses With Interpretive Statements, Washington D.C.; American Nurses Publishing 2001 [Emphasis added].
> *Cavico & Cavico* explained, that:

> "Of particular note is the ethical duty set forth in the ANA's Code obligating the nurse to be an **advocate for patients**. The ANA Code of Ethics provides that '[t]he nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient…In addition, pertaining to the nurse's advocacy obligations, there is a "whistleblowing" section called "Acting on questionable practice,' which describes in detail and in a highly legalistic manner the nurse's ethical duty to report, "incompetent, unethical illegal or impaired practice by any member of the health care team or health care system" [*Cavico supra* @ p. 218 citing ANA Code of Ethics]. [Emphasis added].

Landin's chief obligation was to be an advocate for his patients. [Appx 1 p. 5**b**]. Landin's professional duty to report malpractice is protected within the meaning of MCLA 333.20176(a). The public policy to be an advocate for patients is also well documented in the Nursing Code of Ethics.[47] Landin was acting not only for his deceased patient, Jack, but for the patients at Healthsource who were unwittingly potential victims of Gayle Johnson's "startling, if not appalling, lack of knowledge". [Appx 56, 212**b**]. (Emphasis added).

In response, Appellant argues the "nursing profession contains no indication that it is intended to preserve the right of nurses to make internal reports so coworkers can receive education and counseling". [Appellant brief p. 46]. Appellant mischaracterizes Landin's report. Contrary to the above, the purpose of the Concern Report authored by Landin and submitted to Boyk, in the chain of command, was for many purposes:

1) To report that the neglect of Johnson killed or precipitated the death of "Jack";
2) To document the neglect, and malpractice of LPN Gayle to demonstrate the severity of the malpractice and neglect;
3) To document those things that LPN Gayle did not do properly, in part; and

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[47] As noted, Landin testified regarding his professional responsibility and the Appellee spent significant time addressing the professional responsibility issue in its brief to the Court of Appeals. *See*, Appellee's brief below pp. 29-30. The Court of Appeals did not address the issue of Landin's professional responsibility to protect patient safety as it believed it was unnecessary in light of Section 333.20176a of the PHC. However, the professional code of conduct, as adopted by the Legislature in the Michigan Administrative Code, is an independent and legislatively mandated source of public policy. It also provides an additional "missing link" that was not present, but recognized as a source of public policy, in *Terrien*.

4) To document that Jack's death was avoidable and to advise his supervisor that LPN Gayle, was "dangerous" and posed a threat to other Healthsource patients, and that they needed to talk to determine what other actions needed to be taken. [Appx 39, p. 180a].

These purposes, contrary to the assertion of Appellant, are consistent with the Michigan Constitution, The Michigan PHC, and Landin's professional responsibility as dictated by the his Code of Ethics and as codified in the Adm. Code through the regulation of nurses. Johnson was objectively dangerous and posed a threat to the health and safety of any patient she treated.

Worse, however, is the Appellant's mischaracterization of the Court's holding in *Terrien supra.* The Appellant asserts that *Terrien* prohibits using professional codes of conduct as a foundation for a public policy. The Appellant states as follows:

> "Plaintiff may try to leverage a public policy claim based on the Code of Ethics for Nurses with Interpretive Statements. This is exactly what *Terrien* outlawed as these are privately created standards and cannot, because of that, be the basis for a public policy claim". [Appellant's brief p. 31 fn 19].

Contrary to being what *Terrien* outlawed, The Code of Ethics, in this case adopted through the Michigan Administrative Code, is exactly the type of source that the *Terrien* Court endorsed as the legitimate foundation for public policy.[48]

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[48] "**We note that, besides constitutions, statutes, and the common law, administrative rules and regulations, and public rules of professional conduct may also constitute definitive indicators of public policy**". See *Terrien supra*, FN 11, p. 67, (Emphasis Added). These are not merely privately created standards without government endorsement. Rather, they are standards that are subsumed within the regulation of nurses, and are referenced in the Michigan Administrative Code. Training and standards are expected of all licensed nurses to enhance public safety and welfare.

Likewise, in the same footnote, Appellant asserts that *Suchodolski* concluded that a private association code of ethics did not establish public policy. [Appellant brief p. 31 fn 19]. However, stated in context, the Court in *Suchodolski* explained the case only involved "a corporate management dispute" and the regulation of accounting system of utilities is not directed at conferring rights on employees. *Suchodolski supra* pp. 696-697. The nurse's code of professional responsibility, as subsumed within the Michigan Administrative Code, does put duties and obligations on nurses to protect and advocate for patients in pursuit of public safety and welfare. This case presents the situation as identified in *Terrien supra* where "public rules of professional conduct" is a definitive indicator of public policy.

Sister jurisdictions that have considered the question have ruled in conformity with the Court of Appeals herein. The Iowa Supreme Court addressed virtually an identical situation to this case. *Dorshkind v. Oak Park Place of Dubuque*, 835 NW 2d 293 (Iowa 2013).

Dorshkind was hired by Defendant, Oak Park, as an "at-will" employee. Oak Park was an assisted living facility. Under Iowa law, a facility that was certified for dementia patients had to provide special dementia training to its employees. [Id @ 296]. During a surprise inspection by the Iowa Department of Inspections and Appeals, Dorshkind witnessed her new supervisor, Hendricks, and a subordinate, falsifying state mandated training documents for the dementia program. The two individuals boasted they were "[saving] the day" for Oak Park. [*Dorshkind, supra*, @ 296-297]. As Hendricks was her direct supervisor, she could not report the wrongdoing to him. Rather, she reported the activity to her former supervisor, Martha Jones, who was now working out of town. Dorshkind's concern, as was Landin's herein, was for the well being of the patients. Jones, after being apprised of the forgeries, contacted the Director of Human Resources, Tara Klum. Klum then claimed that she and another official went to investigate Dorshkind's claim, just as Amber Boyk claimed in this case. Also like Boyk, Klum never actually interviewed Dorshkind just as Boyk did not interview Landin, nor did she interrogate, question, or investigate Gayle Johnson. After two days Klum concluded that there was no validity to Dorshkind's claims. The following day, Oak Park terminated Dorshkind for "not being truthful", and "spreading rumors". [*Dorshkind supra* @ p. 298].

Dorshkind filed a complaint alleging wrongful discharge. Defendant responded by filing a motion for summary disposition claiming that Dorshkind did not make a report to the Iowa Department of Inspections and Appeals. The Court noted:

> On September 7, 2010, Dorshkind sued Oak Park for wrongful discharge of employment in violation of public policy. Oak Park responded by filing a motion for summary judgment, arguing no established public policy protects Dorshkind's activity because she did not report the alleged misconduct externally to the DIA, but rather, only internally. [Id @ p. 299].
>
> After a jury verdict for Dorshkind, the Sup. Ct of Iowa framed one issue as follows:
>
> "The first issue is whether an at-will employee, who was discharged by her employer after making an internal report of forgery regarding state-mandated documents certifying dementia training, is protected from retaliatory termination under the public-policy exception to the at-will employment doctrine". [*Dorshkind supra* @ p. 299].

The Court recognized that in Iowa that employment is at-will. However, as this Court has recognized, the Iowa Court also recognized public policy exceptions to the employment at-will doctrine. The *Dorshkind* Court explained that the public policy exceptions in Iowa are virtually identical to the exceptions found in *Suchodolski*. The Court explained,

> "[a]n employee seeking protection under the public-policy exception in his or her wrongful-discharge claim must prove the following elements:
>
> (1) the existence of a clearly defined and well-recognized public policy that protects the employee's activity; (2) this public policy would be undermined by the employee's discharge from employment; (3) the employee engaged in the protected activity, and this conduct was the reason the employer discharged the employee; and (4) the employer had no overriding business justification for the discharge. Citing *Berry v. Liberty Holdings*, 803 N.W.2d 106 at 109—10 (Iowa 2011).

The *Dorshkind* Court, affirmed the jury's verdict holding that the internal report was protected under Iowa's public policy. The Court explained,

> "We consider the impact of the discharge on both the dismissed employee and other employees. An essential element of proof to establish the discharge undermines or jeopardizes the public policy necessarily involves a showing the dismissed employee engaged in conduct covered by the public policy. If it can be shown the whistleblower engaged in conduct in furtherance of public policy, and was dismissed for doing so, and that discharge will discourage other employees from engaging in the same conduct, then public policy is undermined. *Dorshkind v. Oak Park Place of Dubuque*, 835 NW2d 293,306 2013 Iowa Sup. Ct. Lexis 91 (2013) (citations omitted).[49]

[49] *Also see* other state supreme court decisions. In *Hausman & Wright v. St. Croix Care*, 214 Wis 2d 655, 571 NW2d 393 (1997) the Wisconsin Supreme Court reversed a grant of summary

The rationale detailed in *Dorshkind* only makes sense as most employees will follow the chain of command, as Landin was instructed to do, and report the wrongdoing to his/her immediate supervisor. If that conduct is chilled, public safety will suffer.

b. The Michigan Administrative Code Consists of Legislatively Adopted Rules and Regulations that Demonstrate the Legislature's Intent to Guarantee that Nurses Perform their Professional Responsibilities in a Manner to Protect, Preserve, and Improve the Health, Safety and Welfare of Michigan Citizens Through Licensing and Regulation.

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disposition and held that employer who discharged an employee for her fulfillment of her obligation to prevent abuse and/or neglect in a nursing home creates wrongful termination liability. The Court noted, "A wrongful discharge is actionable when the termination clearly contravenes the public welfare and gravely violates paramount requirements of public interest. [citations omitted]. Accordingly, 'an employee has a cause of action for wrongful discharge when the discharge is contrary to a fundamental and well-defined public policy as evidenced by existing law". [*Id.* 214 Wis 2d 655, 663-664].

In *Wendeln v. The Beatrice Manor Inc.*, 271 Neb 373; 712 N.W. 2d 226 (2006) the Nebraska Supreme Court recognized a public policy claim for retaliatory discharge where an employee was discharged for making a report to the Nebraska Dept. of Health & Human Services. The Defendant, Beatrice, argued that there is no clear legislative enactment declaring an important public policy for wrongful discharge. [*Id* @ 385]. The Court found that the purpose of the APSA would be circumvented if employees mandated by the APSA to report suspected patient abuse could be threatened with discharge for making such a report...Thus, we determine that a public policy exception to the employment-at-will doctrine applies to allow a cause of action for retaliatory discharge when an employee is fired for making a report of abuse as mandated by the APSA. [*Id* @ 387-388].

The Kansas Supreme Court reached the same result in *Palmer v. Brown*, 242 Kan. 893; 752 P.2d 685 (1988). In *Palmer* the plaintiff was allegedly terminated for reporting improper Medicaid billing practices. The Court concluded: "Public policy requires that citizens in a democracy be protected from reprisals for performing their civil duty of reporting infractions of rules, regulations, or the law pertaining to public health, safety, and the general welfare. ...[w]e have no hesitation in holding termination of an employee in retaliation for the good faith [report] ...is an actionable tort. [752 P2D 685, @ 689-690].

Finally, the Colorado Supreme Court, using the codes of professional responsibility just as the Court noted in *Terrien supra*, (FN 11), found that the employee was discharged in violation of public policy where the State of Colorado Board of Accountancy Rules and Regulations provided the foundation for a public policy lawsuit as an exception to the at-will employment doctrine. See, *Rocky Mt. Hosp. & Medical Serv v. Mariani*, 916 P2.d 519; 1996 Colo. Lexis 167 (1996).

The Michigan Administrative Code is a compilation of all adopted rules and regulations that are in effect in the State of Michigan. Each rule is assigned a rule number, which appears at the beginning of each rule in the text of the Code. [State of Michigan website www.mi.gov].

The mission statement of the Bureau of Professional Licensing is to "**protect, preserve and improve the health, safety and welfare of Michigan's citizens through the licensing and regulation of occupational and health professionals.**" [Id. @ "Welcome to the Bureau of Professional Licensing"]. [Emphasis added]. Consistent with that mission statement, The Board of Nursing Rules were adopted by 1978 PA 368, MCL 333.17201 *et seq* and most recently those amended in 2003. The Legislatively adopted rules governing the education and licensing of an LPN, include the following:

> R 338.10307 Curriculum; organization, development, implementation, control, and evaluation.
> Rule 307.
> * * *
> (4) The course content and other learning experiences shall promote student growth in all of the following areas:
> (a) **The understanding of the roles and responsibilities of the members of the nursing profession**.
> (b) **The application of the principles of nursing and the sciences which are basic to nursing practice in the development of plans of care for the patient or client**.
> * * *
> **(h) Understanding and protecting the rights of patients or clients**.
> (5) **All cooperating agencies selected for clinical and laboratory experiences shall have standards of nursing care which demonstrate concern for the patient or client and evidence the skillful application of all measures of safe nursing practice**. See, R 338.10307 [Emphasis added].

These rules and regulations that incorporate a nurse's professional responsibilities for the protection of "and protecting the rights of patients" provide a valid source of public policy pursuant to the Court's decision in *Terrien*.

The Appellant makes a variety of spurious arguments that are not supported by a plethora of irrelevant and/or unpublished decisions. [*See* Appellant Brief pp. 26-27]. The only

published opinion the Appellant cites in this regard is *Psaila v. Shiloh*, 258 Mich App 388; 671 NW2d 563 (2003). In *Psaila* the plaintiff claimed that there was a "public-policy" exception to at-will employment found in the Sales Commission Act (SCA). The SCA, however, only required employers to pay commissions to a terminated employee. The SCA provided no policy that suggested that a salesperson could not be terminated. The court noted, "nothing in the statute prohibits an employer from terminating a sales representative. Quite the contrary, [the Act] only provides a cause of action for sales representatives who have already been terminated" *Psaila* @ p. 393. Appellant then cites a string of irrelevant unpublished decisions that are distinguishable and are not germane to any issue in this case.[50]

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[50] *See* Appellant's Brief pp. 26-27 cites, *Zub v. Wayne County Commission* 1997 WL 33344618 (1997) [Claim was that discharge was in violation of ERISA to prevent attainment of a pension and for reverse race discrimination. The Plaintiff in *Zub* could not identify any Michigan policy that was violated. (*See, Zub, supra*, Appx. 44 p. 192**a**). Other inapplicable unreported cases cited by Appellant include the following: *Friend v. Village of North Branch* 2005 WL 599705 (police officer sought public policy claim regarding home building regulation). Nothing in the statute applied to individuals. To the extent that the discharge was in retaliation for the report or the threat to report to a state agency the claim was a Whistleblower's action. [Appx. 45 pp. 193-195**a**]. Appellant cited *Regan v. Lakeland Regional Health System*, 2001 WL 879008 that involved a plaintiff's attempt to sensitize her employer to Medicare fraud. The Plaintiff's failure to report precludes her reliance on either the federal legislation or Michigan's Whistleblower's Protection Act. Moreover, she cited no constitutional, statutory, of any legislative policy that suggested that employees were protected for "sensitiz[ing]" their employers to "potential fraud". Appx. 46 pp. 196-197**a**]. Defendant's reliance on *Scott v Total Renal Care*, 194 Fed Appx. 292 (2006) is misplaced. In *Scott*, the Plaintiff made a claim under the Whistleblower Protection Act. The Court held because the Plaintiff had a claim under the WPA, "...that Scott's public policy based claim could not proceed because the WPA is the exclusive cause of action governing employer retaliation" where employees made a report to a state agency. [Appx. 54 pp. 239-240**a**]. The plaintiff in *Scott* reported inadequate staffing issues to "State" authorities. [Id @ 239**a**]. The Plaintiff, herein, made no such report, nor did he threaten to report. His public policy matter can proceed as Landin had no recourse under the WPA. [*See Infra*]. Reliance on *Turner v. Munk*, 2006 WL 3373090, is also misguided. In *Turner*, the Plaintiff was an office manager who, apparently, was helping herself to the property of the Defendant's practice. The plaintiff claimed that her request for overtime, some seven months before her termination, was the basis of the retaliatory termination. The court found, that the defendant provided a legitimate reason for the plaintiff's termination, theft, which the plaintiff failed to rebut. Appellant makes a similar error in *Grant v. Dean Witter Reynolds*, 952 F Supp 512 [ED MI 1996]. In *Grant*, the

Appellant, in a desperate attempt to avoid justice, protect those individuals who collectively precipitated the death of a Healthsource patient, conspired to keep it a secret, created fictitious documents under the name of a deceased nurse to support its illegal conduct, and, in the process, jeopardized the health and safety of countless Healthsource patients, partakes in poetic license and hyperbole throughout its brief. Exclaiming at different points that the Court of Appeals decision will send us back to the world created by *Toussaint v. Blue Cross & Blue Shield of Michigan*, 408 Mich 579; 292 NW2d 880 (1980) [Appellant Brief p. 23]; claiming that individuals who can't meet a *prima facie* case of race discrimination will now bring public policy claims [Appellant Brief p. 30]; claiming that the Court of Appeals ignored the *stare decisis* value of *Dudewicz* (a case that supports the Plaintiff/Appellee herein)[Appellant Brief pp. 30-31][51]; repeatedly inferred that the Court of Appeals decision herein gutted this Court's decision in *Terrien supra*, and prepared the world for an onslaught of public policy claims brought as a result of the court of appeals decision in this case.

The reality is that none of these "Chicken Little" claims are true. To have a public policy claim one still needs to meet at least one of the three exceptions to at-will employment found in *Suchodolski supra*. The roadmap for public policy claims was further clarified in *Terrien supra*. Despite the ruling and roadmap in *Terrien,* there was no flood of new litigation nor have we been relegated to world created by *Toussaint.*

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plaintiffs claimed that Dean Witter violated the Michigan Partnership Act (MPA) by discharging them for suing under the Act. The section relied on by the plaintiffs, however, were sections that conferred general obligations of partners and did not confer any rights as to employees.

[51] *Dudewicz* support the Appellant herein. Appellant's own citation to the case makes this crystal clear. A public policy action is excluded if one has or had a viable claim under the WPA. However, because the Appellee Landin, is not a whistleblower, because he did not report, nor did he threaten report any wrong doing to a "public body". Therefore, because he was not a "whistleblower" the WPA provided no remedy and a public policy claim may go forward.

Likewise, as this Court explained in *Terrien*, a plaintiff must be able to demonstrate that public policy if firmly rooted in constitutions, statutes, the common law, administrative rules and regulations, and/or public rules of professional conduct.

Contrary to the claims of the Appellant, the real danger in this case is to allow incompetent medical providers, and/or their unethical supervisors, from hurting, maiming, and killing patients in Michigan medical facilities. The failure to protect Landin will empower those who are inept and/or unethical and will have a chilling effect on those medical providers who want to act in conformity with their professional obligations, the Michigan Constitution, the PHC, and the Michigan Administrative Code to report malpractice.

Gayle Johnson, a nurse who had historically been repeatedly counseled, removed from the skilled nursing floor by her contemporaries, was not able to prioritize as evidenced by the death of Jack, and generally had a shocking lack or nursing knowledge and was, at least at the time of trial, objectively incompetent was allowed to continue at Healthsource without so much as counseling. Landin, a decorated military nurse, with extensive combat training, and who was reviewed by Healthsource as excellent nurse, was excised by Healthsource not because of his incompetence, but because he was an advocate for his deceased patient, as well as other Healthsource patients who assumed that they would receive competent nursing care.

ARGUMENT II

THE WHISTLEBLOWER PROTECTION ACT (WPA) IS NOT THE APPELLEE, ROBERTO LANDIN'S, EXCLUSIVE REMEDY IN A CLAIM FOR WRONGFUL DISCHARGE IN VIOLATION OF PUBLIC POLICY, WHERE THE WPA PROVIDED NO REMEDY BECAUSE LANDIN IS NOT A "WHISTLEBLOWER" AS THAT TERM IS DEFINED PURSUANT TO THE WPA.

The Appellant's argument that the Whistleblower Protection Act (WPA) is Landin's exclusive remedy because a public policy claim is duplicative of rights within the WPA (see generally Appellant's brief pp. 27-28) is fatally flawed. Implicit in the Appellant's argument "of

an exclusive remedy" is that the WPA provided "a" remedy for Landin. Because Landin is not a "whistleblower" as that term is defined within the WPA, he had **no** remedy under the WPA. As the WPA provided no remedy, it cannot be duplicative or the plaintiff's exclusive remedy.[52]

A. LANDIN IS NOT A "WHISTLEBLOWER" AS THAT TERM IS DEFINED IN THE MICHIGAN WPA AND, THEREFORE, LANDIN HAD NO REMEDY UNDER THE WPA.

Section 2 of the *Whistleblowers' Protection Act* provides in relevant part:

> An employer shall not discharge, threaten, or otherwise discriminate against an employee regarding the employee's compensation, terms, conditions, location, or privileges of employment because the employee, or a person acting on behalf of the employee, reports or is about to report, verbally or in writing, a violation or a suspected violation of a law or regulation or rule promulgated pursuant to law of this state, a political subdivision of this state, or the United States **to a public body.**[53] [M.C.L. § 15.362 (emphasis added).]

There is no dispute that Landin never reported, nor did he ever threaten to report, the negligent killing of Jack, or the general incompetence and danger that nurse Johnson presented to

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[52] The argument is reminiscent of "bound submission" practiced during the Salem Witch Trials. In this test the alleged witch would be bound, with a heavy rock attached, and thrown into a body of water. If the woman's body floated to the surface (she could swim despite the rock), that was proof that the accused was indeed a witch, at which point they would execute her. If she sank to the bottom – and inevitably drowned – she was innocent. There was no avenue for redemption. Likewise, Landin had no path to redemption using the WPA.

[53] **In the definitional section of the WPA "public body" is defined as follows:**

d) "Public body" means all of the following:

> **(i)** A state officer, employee, agency, department, division, bureau, board, commission, council, authority, or other body in the executive branch of state government.
>
> **(ii)** An agency, board, commission, council, member, or employee of the legislative branch of state government.
>
> **(iii)** A county, city, township, village, intercounty, intercity, or regional governing body, a council, school district, special district, or municipal corporation, or a board, department, commission, council, agency, or any member or employee thereof.
>
> **(iv)** Any other body which is created by state or local authority or which is primarily funded by or through state or local authority, or any member or employee of that body.
>
> **(v)** A law enforcement agency or any member or employee of a law enforcement agency.
>
> **(vi)** The judiciary and any member or employee of the judiciary.

an unwitting public, to any "public body". [*See*, Appellant's brief. p. 36; *Also See* Appx. 57 p. 214**b**]. Because he was not a "whistleblower", the WPA provided no remedy for Landin.[54]

The general rule cited by Appellant, that where there is a new right or duty created or imposed by statute, the remedy provided for enforcement of that right is exclusive, does not apply to situations where a remedy does not exist, is inadequate, and/or deficient. *Mack v. City of Detroit*, 254 Mich App 498; 658 NW2d 492 (2002). Stated another way, "[i]f, the WPA does not apply and provides no remedy, neither can it be plaintiff's exclusive remedy". *See Dudewicz, supra*; *Driver v. Hanley*, 226 Mich App 558; 575 NW2d 31 (1997); A public policy claim cannot be barred as duplicative of a WPA claim where the WPA claim does not exist.

The Court of Appeals correctly found that:

> "Defendant further contends that plaintiff's claim falls squarely within the WPA and that it was thus plaintiff's exclusive remedy so that summary disposition was appropriate in defendant's favor. We disagree.
>
> The Public Health Code provides, at MCL 333.20180:
> A person employed by or under contract to a health facility or agency or any other person acting in good faith who makes a report or complaint including, but not limited to, a report or complaint of a violation of this article or a rule promulgated under this article; who assists in originating, investigating, or preparing a report or complaint; or who assists the department in carrying out its duties under this article is immune from civil or criminal liability that might otherwise be incurred and is protected under the whistleblowers' protection act, 1980 PA 469, MCL 15.361 to 15.369.
> * * *
> If plaintiff was simply reporting a violation of an article or rule under the Public Health Code, defendant's argument would succeed, given that the remedies provided by the WPA are exclusive and not cumulative. *Shuttleworth v Riverside Hosp*, 191 Mich App 25, 27; 477 NW2d 453 (1991). However, plaintiff did not originate a report or complaint alleging a violation of the Public Health Code, he accused a coworker of malpractice.
> * * *
> There is no requirement that in order to establish a claim of malpractice, one must

[54] Appellant wrongfully implies Landin did not meet the requirements of the WPA because he did not "file his complaint in the requisite period of time" [Appellant pp. 20-21]. That is deceptive. Rather, Landin did not report wrongdoing to a public body and, therefore, is not a "whistleblower". It did not matter when Landin filed his Complaint, he would never qualify as a "whistleblower".

necessarily allege a violation of the Public Health Code. The trial court did not err by denying defendant's motion for summary disposition based on the WPA.
Landin v. Healthsource Saginaw 305 Mich App 519, @ 532-533; 854 NW2d 152 (2014) *lv grt* 860 NW2d 927 (April 3, 2015) [Appx. 9 p. 35**a**].

B. THE APPELLANT'S RELIANCE ON AN UNPUBLISHED, SPLIT DECISION, IN *PARENT V. MT. CLEMONS HOSPITAL* IS MISPLACED.

Appellant's wrongfully asserts that the WPA is the exclusive remedy herein. Appellant relies almost exclusively on *Parent v. Mount Clemens Gen Hos*, 2003 WL 21871745 (August 7, 2003), a split, and unpublished decision. [Appellant's brief p. 36, Appx. 51 p. 217**a**]

The split decision in *Parent* allegedly standing for the proposition that a public policy is barred by a corresponding WPA claim is *dicta*. The death-knell to Parent's claim was not that the WPA was the exclusive remedy. Rather, Parent did not present a *prima facie* case of a viable public policy claim. In footnote 2, the majority noted:

> "Furthermore, even if an independent action were sustainable as a matter of law, plaintiff here failed to establish a genuine issue of fact regarding whether she reasonably believe the defendant was engaged in malpractice or that she was discharged because of her objections to the training method". [*Parent supra*, Appx 51 p. 219**a**].(emphasis added).

Judge White, in the dissent, correctly declared that *Parent* **could not** have been protected by the WPA, and, therefore, the WPA could not be the exclusive remedy. Judge White wrote:

> "**The WPA only applies where the employee reports the alleged violation to a public body. Such conduct was not involved here. The WPA provides no remedy and therefore is not the exclusive remedy**." [Judge White, *Id.* at p. 4]. [Emphasis added].

In relying on the unpublished 2-1 decision in *Parent*, Appellant overlooks and a bevy of published decisions that reach opposite conclusions. In *Driver*, the court declared:

> As a general rule, remedies provided by a statute for the violation of a right having no common-law counterpart are exclusive rather than cumulative. *Dudewicz v Norris Schmid, Inc*, 443 Mich. 68, 78; 503 N.W.2d 645 (1993), citing *Pompey v General Motors Corp*, 385 Mich. 537, 552-553; 189 N.W.2d 243 (1971). The WPA is such a statute. *Dudewicz, supra* at 79; *Covell v Spengler*, 141 Mich. App. 76, 82-84; 366 N.W.2d 76 (1985). The Michigan Supreme Court, in *Dudewicz*, 443 Mich. at 80, held that because the WPA provided relief, the plaintiff's cumulative public policy claim was not

sustainable. The Court explained that a public policy claim is sustainable "only where there is not an *applicable* statutory prohibition against discharge in retaliation for the conduct at issue." *Id.* (emphasis added); see also *Garavaglia v Centra, Inc*, 211 Mich. App. 625, 630; 536 N.W.2d 805 (1995). In this case, the circuit court determined that the WPA was not applicable to the facts regarding plaintiff's discharge. **Because the WPA provided no remedy at all, it could not have provided plaintiff's exclusive remedy**. *Dudewicz, supra* at 80. Therefore, we hold that the circuit court abused its discretion when it denied plaintiff's motion on the ground that the WPA provided plaintiff's exclusive remedy. *Driver, supra*, @ 566.[55] (citations omitted) (Emphasis added).

C. APPELLANT'S READING OF *DUDEWICZ* IS LIKEWISE INCORRECT.

Appellant argues that the Court of Appeals erred in applying *Dudewicz v. Norris Schmid, Inc.*, 443 Mich 68; 503 NW2d 645 (1993) in two ways. First, Appellant argues that *Dudewicz* eliminated the first prong of *Suchodolski*. (Appellant's br. p. 26). Second, Appellant argued

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[55] In *Mack v. City of Detroit*, 254 Mich App. 498; 658 NW2d 492 (2002); the plaintiff filed a sex discrimination claim based on the city charter. The court, citing *Pompey v. General Motors*, 385 Mich 537; 189 NW2d 243 (1971), acknowledged the general rule that when new rights or duties that did not exist at common law are created by statute, the remedy provided for enforcement of that right by the statute is exclusive. *Pompey*, 385 Mich. at 552. It also recognized that the rule presumptively applied because there was no preexisting, common-law remedy for employment discrimination. *Pompey, supra*. However, the court noted that "**the statutory remedy is not deemed exclusive if such remedy is plainly inadequate," and concluded that the plaintiff was not barred from bringing a civil suit to obtain full recovery for his damages**. 385 Mich. at 552-553, n 14, 560. [*Mack supra* @ 501-502]. [Emphasis added].

In *Hall v. Consumer's Energy*, 2006 Mich App Lexis 1766 (Appx. 58, 216-217b) the Plaintiff claimed that he was discharged for reporting, **internally**, safety breaches at a nuclear facility. The trial court dismissed his claims. The court of appeals correctly reversed. Hall had no claim under the WPA as he did not report the wrongful conduct to a "public body". The court declared:

> "However, because the WPA provides no remedy for plaintiff's allegation of retaliatory discharge, the trial court erred in also dismissing plaintiff's claim that his discharge constitutes a violation of public policy. It is well settled that because the WPA represents Michigan's public policy against discharge for reporting suspected violations of law to a public body, any public policy claim of wrongful discharge arising from such activity is preempted by the WPA. See *Dudewicz v Norris Schmid, Inc*, 443 Mich. 68, 70, 78-79; 503 N.W.2d 645 (1993) (the remedies provided by the WPA are exclusive, not cumulative). If, however, the WPA does not apply and provides no remedy, neither then can it be plaintiff's exclusive remedy. *Id.* at 80; see also ***Driver v Hanley (After Remand)*, 226 Mich. App. 558, 566; 575 N.W.2d 31 (1997)**. **Thus, where, as here, the WPA provides no remedy at all, it cannot constitute a plaintiff's exclusive remedy. *Driver, supra*. Consequently, the trial court erred in holding that the WPA precluded plaintiff's claim for retaliatory discharge in violation of public policy**. |*Hall supra*, Appx. 58, p. 217b|.(Emphasis added).

that *Dudewicz* required that the WPA was the exclusive remedy for violation of a right having no common law counterpart. [Appellant's brief pp. 27, 31-32]. Both are incorrect.

In *Dudewicz*, the plaintiff reported a co-worker's assault and battery to the prosecutor. When Dudewicz came to work the next day he was told by management to drop the charges. When he refused, he was terminated. The public policy claim was pre-empted by the WPA, because he was a "whistleblower" and that was his exclusive remedy. The Court explained:

> A public policy claim is sustainable, then, only where there also is not an **applicable statutory prohibition** against discharge in retaliation for the conduct at issue. As a result, **because the WPA provides relief to Dudewicz for reporting his fellow employee's illegal activity, his public policy claim is not sustainable**.
> *Dudewicz, supra* @ p. 80. [Emphasis added].

In this case, however, Landin was not protected under the WPA because he is not a "whistleblower" as that term is defined within WPA. Therefore, the WPA is not **"an applicable statutory prohibition"**. As such, it provided no more of a remedy than any other inapplicable piece of legislation. Bottom line, the public policy claim is the only remedy that Landin had.

D. MCL 333.20176 DOES NOT REQUIRE A NURSE NOTIFY THE PUBLIC HEALTH DEPARTMENT OF A VIOLATION OF THE PHC.

The Public Health Code does not mandate that a person **must** notify a public body of malpractice or a violation of the PHC. Specifically, MCL 333.20176 provides that a person "**may** notify the department of a violation of this article that the person believes exists". Therefore, Landin's internal report of malpractice to his supervisor, consistent with Healthsource policy, furthered the public policy of protecting the health and welfare of Healthsource patients but did not constitute a report to a public body.

E. MCL 333.20176A PROVIDES DISJUNCTIVE RELIEF AND PROTECTS AN EMPLOYEE FROM DISCHARGE FOR 1) IN GOOD FAITH REPORTS, VERBALLY OR IN WRITING, THE MALPRACTICE OF A HEALTH PROFESSIONAL OR A VIOLATION OF THIS ARTICLE,

ARTICLE 7, ARTICLE 15 OR A RULE PROMULGATED UNDER THIS ARTICLE, ARTICLE 7 OR ARTICLE 15.

Under the language of MCLA 333.20176(a) there is no requirement a report be made to a public body. The Court of Appeals explained, Landin merely internally reported "malpractice" and did not make a report to a public body under the PHC. *Landin supra* p. 532-533.

The statement of public policy in MCL 333.20176a has these three elements. The employee must 1) make a good faith report that one has committed malpractice; 2) make the report verbally or in writing; and 3) then suffer an adverse employment action as a result of the report. Mr. Landin proved that he met those three prerequisites to have a public policy claim but did not have a corresponding WPA because he made no report to a "public body".[56]

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[56] Healthsource's asserts that other courts have denied pubic policy claims based on internal reports. Those internal reports, however, had no legislative statements prohibiting discharge (*Suchodolski* exception 1) nor was the termination in response to an employee's exercise of a well-established legislative enactment (*Suchodolski* exception 3). The string of unpublished decisions by Appellant are distinguishable. There is no stated legislative protection for the hiring of a convicted felon. [*See Healthsource's Brief* p. 37 *citing Gilmore v. Big Brothers/Sisters of Flint, Inc* 209 WL 1441568]. *Harder v. Sunshine Senior Living* [2009 WL 5171843] is also distinguishable. In *Harder* plaintiff asserted that her claim for wrongful termination was based on the second prong identified by the *Suchodolski* court, a termination for failure or refusal to violate the law. The Court declared that "Harder's claim that she was fired to prevent her from reporting the nurse's dispensing of the drug to the state of Michigan, failed to state a claim for wrongful termination for failure or refusal to violate the law. Harder's complaint did not, however, allege facts showing that Harder *herself* refused violate any specified law and therefore it failed to state a claim for wrongful termination under this prong of the public policy exception" *Harder supra*. Finally, Healthsource's reliance on *Cushman-Lagerstrom v. Citizens Ins Co*, 72 Fed Appx. 328 (6th Cir 2003). In *Cushman* Plaintiff claimed that she reported an internal report that suggested that she would be violating the law. The Court held otherwise. The Sixth Circuit explained: "We are not persuaded that Plaintiff has established any violation of law or any proposed actions that would have violated the law. Plaintiff merely raised an issue ... to upper management officials, who in turn determined that no violations had occurred or were occurring. Plaintiff has produced no evidence to the contrary" [*Cushman supra @328*]. The Court noted that Cushman admitted that "she was unaware of any actual violation of the letter's terms and she never felt that she should report the perceived violation..." [Id. @ 326]. *Cushman* also cites two other cases, *Wiskotoni v. Mich National Bank*, 716 F2d 378 (6th Cir 1983); and *Pratt v. Brown*, 855 F2d 1225, (6TH Cir 1988). These cases require that the Plaintiff demonstrate the "location of some legislative enactment to ground a finding that a discharge is in breach of public

CONCLUSION

Michigan has a strong public policy to protect the health safety and welfare of its citizens. See MCL 333.1111. That policy is initially rooted in the Michigan Constitution wherein the public health is "declared to be matters of primary public concern". Const 1963 Art. 4 §51. The PHC, in an attempt to guarantee the public is protected from incompetence, subsequently required that its policies be liberally construed so as to protect the health and safety of the citizens of this state. Section 20176a of the PHC is emblematic of the policy to protect health care workers from retaliation for reporting malpractice. However, the evidence of public policy to protect unsuspecting patients from life threatening malpractice does not end there.

This Court in *Terrien*, stated that in addition to constitutions, statutes, and the common law, that "administrative rules and regulations, and public rules of professional conduct may also constitute definitive indicators of public policy". *Terrien* FN 11 p. 67. Landin testified that his role as a nurse is to be an advocate for the patient. The duties and obligations of the Nurse's Code of Ethics are engulfed within the public rules of professional conduct found in the Michigan Administrative Code. The mission statement, consistent with the public policy herein, is to "protect, preserve, and improve the health, safety, and welfare of Michigan citizens through the licensing and regulation of ...health professionals". The Board of Nursing rules were adopted to guarantee that nurses are competent and, in turn, perform their duties in accordance with their Code of Ethics, including "**understanding and protecting the rights of patients or clients**". See Adm Code, R.338.10307(4)(h). Finally, the common law is filled with cases that protect the public health from wrongful retaliation in violation of public policy. The link of legislative statements and public policy missing in *Terrien*, is omnipresent herein.

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policy. [*See Cushman* p. 328]. Landin showed that there are other valid indicia of public policy as announced by this Court in *Terrien*.

Healthsource asks this Court to ignore these mandates, and find that a hospital may terminate a nurse for reporting that an incompetent nurse killed an unsuspecting patient and posed a clear danger to all other patients at Healthsource. Likewise, Healthsource desires that this Court put its stamp of approval on a supervisor destroying personnel files and creating documents, under the name of a deceased nurse, to augment their nefarious and illegal activity. Healthsource is asserting that it is not against the public policy of this state for a hospital to terminate a nurse in retaliation for reporting deadly malpractice. That position is contrary to public policy and against the opinion of virtually every ordinary citizen. Finally, Healthsource asks this Court to be an accomplice to chilling proactive conduct by competent nurses, consistent with their code of ethics and the Adm. Code, and endanger the lives of the Michigan citizens.

The WPA cannot be Landin's exclusive remedy where he is not a "whistleblower" as that term is defined in the WPA. As he is not a whistleblower, the WPA provided no remedy. A statutory remedy is not deemed exclusive if such remedy is plainly inadequate. In this case, the WPA provided no remedy, and therefore is not Landin's exclusive remedy.

The jury, trial court, and the Court of Appeals were outraged by the nefarious and illegal conduct of Healthsource. That conduct, if allowed to go unchecked, unequivocally undermines the health and welfare of the citizens of this state. The termination of Landin for his report of deadly malpractice is against public policy, is an exception to the at-will employment doctrine and the decisions below should be affirmed.

Dated: July 29, 2015

Hurlburt, Tsiros & Allweil, P.C.

BY: _____

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